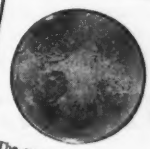
PUBLIC HEALTH

LONDON: THE SOCIETY OF MEDICAL OFFICERS OF HEALTH
Tavistock House South, Tavistock Square, W.C.1

No. 10.-Vol. LXIII. MONTHLY PRICE 2s. 6d. ANNUAL SUBSCRIPTION 31s. 6d. JULY-1950

Hot water for health

These unretouched photographs are of cultures prepared by a Public Health Laboratory making independent scientific investigations into causes of epidemic outbreaks.



The germ-laden finger-prints of a hand not washed after a visit to the toilet.

This seemed a clean hand, but it had picked up many germs in the daily round.

Prints of a hand which had just previously been washed with hot water and soap.

The Food and Drugs Act requires hot water to be available for personal toilet in every commercial establishment where food is handled.

The best source of hot water is one of the Ascot Instantaneous Gas Water Heaters. They are economical and easy to install. There is a model for every need. Inquire at your nearest gas showroom or from:—

Ascot Gas Water Heaters Ltd.

43 PARK STREET, LONDON, W.1.

and at BELFAST · BIRMINGHAM · BOURNEMOUTH · GLASGOW and MANCHESTER.

ASCOT

PUBLIC HEALTH

SOCIETY OF MEDICAL OFFICERS OF HEALTH

Telephone: EUSton 3923 TAVISTOCK HOUSE, TAVISTOCK SQUARE, LONDON, W.C.1 Telegrams: Epidauros, Westcent

No. 10. Vol. LXIII JULY, 1950

CONTENTS

EDITORIAL

C.M.O. of Three Departments

The Society's policy has long favoured unified control in one central department of all the medical and allied services with which the Government is concerned. The tendency in latter years has been in the reverse direction and new medical sections in various Ministries have multiplied and flourished exceedingly, with what internal competition and overlapping only the discreet inner circles of the Civil Service can know.

The brief announcement in *The Times* that Sir John Charles, new Chief Medical Officer of the Ministries of Health and Education, has also been appointed C.M.O. of the Home Office, will therefore be doubly welcomed as a sign that the wisdom of co-ordinated policy is recognised. We have not concealed our view that the local divorce of the care of deprived children from the health department was a mistake mothered by the Curtis Committee; but Sir John's new appointment means that at least the medical inspectorate of the Home Office will be under the same general direction as their colleagues at the other departments which have a special concern for the health of the people.

Fluorine and Wartime Diet

Dr. Robert Weaver, of the Special Services Branch of the Ministry of Education, has, with his usual clarity of exposition, published an article under the above heading in the issue of *The British Dental Journal* of May 5th, 1950.

In 1943 Dr. Weaver carried out a survey of the dental condition of 500 five-year-old and 500 12-year-old children in both North and South Shields, the former being a non-fluoride area and the latter having a water supply containing 1·4 parts per million of fluorine. In other respects—social, industrial and climatic—the neighbouring towns are similar in character. The results obtained were recorded on the basis of DMF teeth, that is to say the number of decayed, missing and filled teeth per child.

In 1949 Dr. Weaver again made a survey of a similar number of children in these same two age groups in the same two areas. Many observers had reported a substantial improvement in the teeth of children during the war years. Mr. W. B. Grandison, Chief Dental Officer of Cambridge, who has kept records over a long period of years of the average percentage of carious deciduous teeth in five-year-old children in the Borough of Cambridge, showed that from 1925 to 1941 the integrated figure was 19·6%; this had fallen to 14·3% in 1942, 9·0% in 1947 and 6·7% in 1949. Lady Mellanby had also observed similar results in an examination of a considerable number of five-year-olds in London within the same period. She held that the wartime diet and allowances had a higher calcifying quality and attributed her results to this factor, but it must be remembered that a similar trend was noted during World War I, and so the lowered consumption of sugar and other refined carbohydrates cannot be ruled out as the cause of the reduction of caries.

Although the war was officially over in 1945, Dr. Weaver does not consider the changes in the national diet since then until 1949 to have been sufficiently marked to have made the term "wartime diet" inappropriate. This second survey was therefore designed to test whether the "wartime diet" had produced any substantial changes in the caries incidence and whether in South Shields there had been any cumulative effect of the "wartime diet" reinforced by the fluorine factor. The results he obtained were most striking. Whereas in North Shields the average DMF teeth per child in the five-year-old group were in 1943 and 1949 6·6% and 4·4% respectively and in the 12-year-old group 4·3% and 2·4%, the results in South Shields showed in one respect a divergence from what might have been expected. In that town in the five-year-old group the figures in 1943 and those first obtained in 1949 were 3·9% and 3·7% respectively. Those for the 12-year-old group had followed the more general pattern and had fallen from 2·4% to 1·3%. Thus three groups out of the four had shown a substantially lower caries incidence in 1949 than in 1943. In order to eliminate any possibility of error in the divergent South Shields five-year-old group a further 500 children were examined, and this time a figure of 3·4% was obtained. When the two sets of figures were integrated a final result of 3·5 was arrived at. Another interesting point that the figures brought out was that the average 1949 DMF teeth per child, and also the percentage of children with no DMF teeth at all in North Shields had been reduced to approximately the 1943 South Shields level. But when the DMF figure for individual teeth was compared that for the upper incisors was very different, being 95% for *NO*rth Shields, the *NO* fluorine area, and 17% for *SO*uth Shields, the *SO*me fluorine area. It therefore appears that the caries inhibiting principle in fluorine is much more effective as regards the incisor teeth than in the molar region.

Dr. Weaver also records in his paper the results of a survey he made in 1949 only in West Hartlepool, a coastal town in County Durham some 25 miles south of South Shields, which had been called to his attention as a possible fluorine area by one of the dental officers now on the staff of the Northumberland County Council. In West Hartlepool the domestic water supply contains two parts per million of fluorine but otherwise the climatic, social and economic conditions are much the same as in the two towns farther north. He found that the caries incidence in the five-year-old group was approximately half that prevailing in South Shields, and the percentage of children with no DMF teeth was almost doubled. In the 12-year-old group the average DMF figure was just under

one tooth per child and 59·8% of the children were entirely free from dental decay, a state of affairs which most school dental officers are only able to dream about. If anyone should imagine that by adding two parts per million to the domestic water supply the problem of dental disease in children could be reduced to easily manageable proprotions, Dr. Weaver quickly disillusions them. He has shown that such a high fluorine content in the water brings in its train a considerable amount of unsightly pigmentation of the tooth enamel. A further examination of 125 15-year-old secondary school children, and 100 mothers of an average of 28·5 years showed that the protection afforded was not permanent, the average DMF teeth in the 15-year-olds rising to 2·1% and in the adults to 8·8%.

Quite apart from Dr. Weaver's investigations in the three towns referred to above, the Ministry of Education have set up a working party to investigate the prophylactic effect of the local application of a solution of fluorides to the teeth of school children. In a written reply to a question in the House of Commons on May 11th, the Minister of Education said that the teeth of about 3,000 children in different parts of the country were now being treated in this way. He said this was a piece of long-term research, the results of which might not be known for some years.

The Ministry of Education is not alone in showing an interest in the effect of fluorine on dental disease, and professional members of the Department of Dental Health of the Ministry of Health are carrying out field work on the subject.

Survey of the Growth of Infants and Young Children

The need for a reliable chart of the growth of infants and young children has been appreciated for some time as those now in use in child welfare centres, hospitals and paediatric practice were prepared many years ago. The intervention of the war, however, made it necessary to postpone any enquiry of this type until recently, when arrangements have been made by the Ministry of Health and the Ministry of Education, in conjunction with the British Paediatric Association, to undertake this in a number of areas in England and Wales. The object of the investigation is to prepare a more reliable and up-to-date chart, and with the co-operation of the medical officers of health and their staffs, the survey, which began in 1949, is being made in selected child welfare centres in Birmingham, Bristol, Cardiff, Finchley, Kent, Leeds, Liverpool, London, Northumberland, Norwich and Rhondda. Dr. Ethel Cassie is supervising the field work on behalf of the Ministry of Health.

It is to be hoped that in the first place approximately 20,000 babies (all of whom enter the survey below the age of two months) will be included and that the survey will continue for at least three years or longer, if possible.

Records are being obtained of the mother's obstetric history, and the infant's birth and subsequent weights taken at regular intervals. The children are examined each time they attend the welfare centres, information is obtained on the type of feeding, and any illnesses occurring between the visits are recorded. The height is measured from 18 months onwards. In addition, various social and economic data are being collected, including the father's occupation, whether or not the mother goes out to work, the size of the family to which the child belongs, housing conditions, and sleeping arrangements. These four sets of data, namely, growth, type of feeding, medical history and social circumstances will be examined together so that their effect on each other can be determined.

The success of this survey depends on the collection and recording of reliable information, which in turn depends on the doctors, midwives, health visitors, nurses and voluntary helpers at the welfare centres. Their ready acceptance of this enquiry and the splendid way in which they are obtaining the required information are the best evidence of their willing co-operation, and it is worthy of note that the mothers of the babies have also shown both interest and a desire to help. All those participating in this work can be assured that their assistance is genuinely appreciated.

The Committee organising the survey under the chairmanship of Dr. J. E. A. Underwood, Ministry of Education, includes Dr. C. P. Pinckney and Dr. G. H. Newns of the British Paediatric Association, Dr. Cecilie Asher of the Ministry of Education, and Dr. H. E. Magee, Dr. Ethel Cassie, Dr. G. I. Brodie and Dr. E. R. Bransby (who is also Secretary) of the Ministry of Health.

Assistance in the planning of the survey is being given by the staff of the Institute of Social Medicine, Oxford, by Dr. J. W. B. Douglas, Director of the Population Investigation Committee, and by the Mathematics Division of the National Physical Laboratory.

Salary Negotiations

A rumour seems to have become current amongst members of the public health service that the negotiations in the Whitley Medical Functional Council's Committee C have broken down or been discontinued. This is not the case. It will be appreciated that it is not possible to publish any detailed reports of the progress of negotiations until a settlement is reached. Two meetings of the Committee have already been held, a third is arranged for the near future and negotiations are very much alive. Members may, perhaps, find it difficult to realise the necessarily slow tempo of such negotiations. It is true that the two sides are not bound to refer back every point to their parent bodies, but such negotiations necessarily take the form of proposals and counter-proposals which have to be carefully considered between meetings and may necessitate the drawing up of fresh documents which must be circulated in advance to the other side. Members are asked therefore to exercise patience in awaiting definite news of the progress of the detailed negotiations about which those in the best position to know are not unduly pessimistic.

Dental Whitley Council

It is encouraging to learn that, despite the difficulties between the main body of dental practitioners and the Minister of Health, the British Dental Association and the Local Authority Associations and Government Departments concerned have agreed to set up a Whitley Council for dentists employed by or in contract with local authorities and that the first meeting was held on June 8th. A claim for improved salaries and conditions of service was lodged by the staff side and is under consideration.

Although the Society can take no direct part in such negotiations, it is noted with appreciation that the B.D.A. has nominated on the staff side several prominent members of the Society's Dental Officers' Group, who have devoted much time, thought and energy to the improvement of conditions of public health dental officers during several years past. It is greatly to be hoped that the situation in the school health and priority class dental service has not deteriorated too far to be remedied. Dr. Charles Hill, in a debate in the House of Commons on May 8th, pointed out very clearly that the root cause of the situation is the overall insufficiency of dentists. If, therefore, the new rates of payment agreed by the Whitley Council are high enough not only to attract entrants from amongst the newly qualified and also to bring back some of the men who have transferred to general practice the priorities situation would be amended, but presumably the pressure would be transferred to the field of general practice. We shall therefore await with keen interest the views of the special party of investigation who went recently to see the work of the New Zealand dental nursing scheme ; and the investigation of caries prevention by application of fluorine (mentioned in another editorial comment) will also be hopefully watched.

Meantime, we can only wish that the patience and loyalty of the public health dental officers who have resisted temptation to leave the work which they like for the greater financial rewards of general practice will soon be recognised by a generous settlement with retrospective effects.

Whither Tuberculosis?

Our contemporary, *Tubercle*, the monthly journal of the British Tuberculosis Association, may not be seen by all medical officers of health, so we propose to quote freely from a letter appearing in the June, 1950, issue, under the above title, whose author is Dr. Lissant Cox, formerly head of the Lancashire Tuberculosis Service. Dr. Cox has for long carried great influence in both public health and tuberculosis circles and his retirement has, if anything, sharpened the acuteness of his observation of what is happening to his old service.

In his letter to the Editor of *Tubercle*, Dr. Cox asks how far it is true that the state of tuberculosis has seriously deteriorated since the operation of the 1946 Act, or whether we have, in balance, better results in prevention and treatment than prevailed under the previous local authority direction and control. His answer is as follows :—

The Act has broken up the old unity of prevention and treatment. This is its most serious effect. The best pre-act schemes were founded on preventive lines or at least prevention and treatment were on an equal footing. It was a question of emphasis or direction. The tuberculosis problem should revolve round the chest clinic, not the sanatorium. The chest physician requires beds under his own care for patients from his clinic area (Clare Hall, Middlesex, has one of the best of these arrangements) else he is but a sham consultant. To acquire experience in general medicine and special training in chest diseases needs a long experience in a chest clinic where the family is the unit. A training in radiology is also essential. Good chest clinics can provide all this. Adequate experience cannot be acquired by residence only in a sanatorium as medical officer, where there are little or no opportunities for the study of diseases other than tuberculosis, and practically none for the study of the normal.

The other major change is central government finance. This makes a much tighter control from Whitehall, a very big change indeed compared with pre-act days when local authorities like Birmingham, Leeds, Manchester, Lancashire, Middlesex, cut a path through the jungle of inertia and got things done. This centralised finance makes the Ministry, in all its sections, of greater importance than before, because the regional hospital boards are more dependent on guidance by the Ministry, than local authorities before the act. There is urgent need of a reorganisation of the tuberculosis section of the Ministry. Far too long it has been woefully weak. This naturally links up with the recent deplorable recommendation of the Ministry and Treasury for a lower rate of pay for local authority work done by the chest physician, work mainly preventive. Who except those who live in the remote and rarefied atmosphere of Whitehall could have suggested one rate of payment to ask a patient how he is, and another rate of payment to ask how his contact wife or child is? To trace this to its source, we must go back to the lavish and alluring terms offered and accepted by "specialists," a decision made without much, if any, thought of specialists in public health services. While the terms pacified a section of the medical profession, no proper attention was paid to the grading of different classes of specialists according to responsibilities, so that we have the serious present anomalies of posts carrying similar work or responsibility paid either at S.H.M.O. rate or consultant rate. But equally strange, and I submit wrong, is the de-grading as regards pay and therefore status, of administrative work or direction. It is true many clinicians felt in the past that they had a raw deal relative to the administrators. The boot is indeed now on the other foot! But if administration means encouragement, direction, and ultimate responsibility for the journey into the unknown, surely it should rank at least equal (I would put it higher) to clinical work.

He ascribes present views to a general attempt by the lay civil servant to hold all professional experts in subjection, on the theory that administration is an entity in itself which can be taken on by a "clever" man without any initial knowledge of the particular service or not. He suggests that action or remedies which could be adopted within the framework of the present Act are :—

(1) Preventive work must rank at least equal with treatment, and be paid at the same rate.

(2) The tuberculosis section of the Ministry of Health must be reorganised—and long ago should have been—and staffed by those who know from experience every aspect, epidemiology, prevention, treatment, rehabilitation.

(3) The Standing Advisory Committee needs strengthening by the addition from different regions of two or three senior chest physicians with university lectureships.

(4) The N.W. Metropolitan Region, guided by the capable hand of Dr. Macaulay, should be followed in its excellent lead, and similar Tuberculosis Advisory Committees should be formed at regional level in each region. It compares with the old Lancashire Tuberculosis Committee which, being on equal footing with other committees, was able to get things done.

(5) There should be a university post of Professor or meantime a Lecturer in Tuberculosis in each Region, as had already been done before the act in Birmingham, Cambridge, Leeds, Manchester and Sheffield.

Coeliac Disease

Coeliac disease, which appears to be on the increase, has for long baffled the world of medicine. Much of its mystery is that which is common to all conditions for which there is no known pathology. In its florid state—pale, soft, voluminous, frequent stools, occurring intermittently with irritability, weakness and general ill-health, a failure to grow, emaciation and a large abdomen—coeliac disease is an obvious diagnosis; but in its earlier stages, and no doubt in less definite instances, it is often missed. As it appears most commonly under six years of age and, despite evidence to the contrary, exists in the first year of life the possibility of its existence needs to be kept in mind by all engaged in child welfare.

The April, 1950, issue of "*Postgraduate Medicine*" (U.S.A.) gives an encouraging account* of 603 cases treated on the hypothesis that the immediate disability results from the ingestion of carbohydrates—not all carbohydrates but all except those found in fruits (and some vegetables). The regimen is most severe and lasts a full year, after which the full range of carbohydrates is gradually added until the diet is once more normal. If rigidly conducted the regime appears to result in cure. The basis of the diet is ripe banana and milk prepared in such a way (details are given) that all lactose is eliminated; meat, fish, fowl and cheese are added without removal of fat; honey, fruit juice, raisins and dates (except those packed in sugar syrup). The addition of quite small amounts of ordinary sugar, carbohydrate or potato usually precipitates a return of diarrhoea. As the authors suggest, this seems to take us appreciably nearer to the elucidation of the mystery of coeliac disease and meanwhile suggests a useful empirical treatment.

A Hundred Years Ago

The Wellcome Historical Medical Museum has once again drawn up its wealth of documentary, pictorial and factual evidence from the past to show, this time, the state of medicine and its allied sciences in the middle years of the 19th century. The Director of the Museum (Dr. E. Ashworth Underwood) and the Trustees are to be congratulated on the interest of and lessons to be learned from the current exhibition illustrating "Medicine in 1850" at 28, Portman Square, W.1, opened with a fascinating address on May 30th by Prof. Henry Sigerist, the noted medical historian, formerly of Hohnes Hopkins Medical School.

We are glad to note that the School Health Service Group of the Society is to meet at the Museum on July 21st and to hear an address from Dr. Underwood on "The Health of the Child a Century Ago."

Lastly, mention should be made of the Catalogue† to the Exhibition which is worth acquiring in itself for the wealth of information it gives on the period, and especially for its introduction by Dr. Underwood.

---

* Diagnosis and Treatment of Celiac Disease. Report of 603 Cases. Sidney V. Haas and Merriall P. Haas, New York City.

† Catalogue of an Exhibition illustrating Medicine in 1850. (Pp. 64. Illustrations. Price 3s. net. Published for the Trustees by Geoffrey Cumberlege, Oxford University Press, 1950.)

During the course of the B.M.A.'s annual meeting in Liverpool, the Dawson Williams lecture is to be delivered by Prof. Alan Moncrieff (Professor of child health, University of London) with the title of "Child Health and the Future," on Thursday, July 20th, at the Chemistry Theatre, Glossage Buildings, Liverpool, at 4 p.m. Members of the public health service are cordially invited to attend.

NEW PATHS IN PUBLIC HEALTH *

By FRED GRUNDY, M.D., D.P.H., BARRISTER-AT-LAW,

Mansel Talbot Professor of Preventive Medicine in the University of Wales

When the form of the National Health Service became known, now almost two years ago, a sense of bewilderment and despondency cast their mantle on the great body of medical officers of health in all parts of the country. The major local authorities were shocked by the loss of hospitals and specialist medical services. The so-called minor authorities were stung by the virtual extinction of their powers in relation to personal health services. The treatment of venereal diseases and the effective control of tuberculosis passed out of the hands of medical officers of health who had rightly come to regard them as among the important preventive services for which they were responsible. Many medical officers serving both major and minor authorities suffered perhaps the unkindest cut of all by the loss of infectious diseases hospitals and in many places by the loss of maternity hospitals which were the central feature of closely knit maternity services. Not, mark you, midwifery or obstetric services, but *maternity* services, which are far wider in scope and purpose, and often embody preventive and promotive elements we have come to regard as being within our special province.

In country districts, formerly independent M.O.H.s found themselves subordinates in larger units, virtually stripped of the administrative initiative they had become accustomed to enjoy—and on the whole used well to the advantage of smaller communities in the decades before the war. There are signs that the badly mauled health department are recovering some of their former confidence, but with certain exceptions it is evident that M.O.H.s and local health committees are not yet working towards defined goals with the enthusiasm—yes, almost with the missionary zeal—that inspired their outstanding achievements in the past. It has been hard enough for medical officers to adjust themselves to the material losses suffered by health departments, but harder still for them to regain confidence in themselves in the face of the intangible effects of recent changes. It is no use blinding ourselves to the fact that the prestige of the M.O.H. has suffered in the eyes of his committee. His professional status has been reduced in the eyes of medical colleagues in medical practice, who—mainly because of his key position as a hospital administrator—had come to regard the success of the M.O.H. with respect touched sometimes with envy.

In the somewhat ruthless scramble to secure levels of remuneration adequate to offset the reduced internal value of the £—in the struggle to hold not a superior position in the salary scale, but a position relatively the same as they had reached in 1938—the M.O.H. and his colleagues in the Civil Service have been beaten to the post by a runaway field. Recruitment to public health is drying up. In the Welsh School, for instance, instead of ten or a dozen D.P.H. students a year, as there were in the '30s, there were none last year and there are two this year ; and as you know, it is the same all over the country.

Now, I know no more than you—perhaps less than some of you—of the calculations and pressures to which this state of affairs can be attributed. To some extent, doubtless, it was no more foreseen than the anomalous depletion of local authority dental staffs at the very time the Minister sought to establish a priority service for children and pregnant women to protect them from the blast of competition for treatment while there were not enough dentists to go round. To some extent is it probably a subsidiary consequence of the stalemate reached in relation to the rationalisation of local government ; and particularly of the unresolved problems of the financial relation between central administration and peripheral bodies retaining a desirable degree of autonomy.

As I say, I am in no position to tell you more than you know about the events which have brought local government medical services to their present pass. But, as I am to examine " New Paths in Public Health " against this background, I am compelled to refer to the reasons for and the implications of the M.O.H.s reactions to the new order.

As this is a family gathering, so to speak, let me say at once that I believe the main features of the new administration to be a great advance. Mistakes have been made, of course, as they always are when far-reaching changes are made abruptly. Midwifery services have received a setback from which they will not recover for a long time. It is by no means clear how an adequate substitute for the special knowledge of clinical fevers needed in the executive field of epidemiology is to be provided in the future. And above all, I cannot see how the new administration can provide a well integrated tuberculosis service to replace the now dismembered service whose parts have been scattered to the four winds. I have heard no one who speaks with authority say that he was quite happy about the new administration of this service. Its present disposition is administratively logical and medically justifiable, but the gravity and the size of the problem of respiratory tuberculosis seem to me to mark it as an exceptional problem requiring exceptional treatment. This, however, is only my own opinion, but leaving aside detail, whether the new service is good or bad, right or wrong, I have no doubt that the curtailment of the scope of M.O.H.s responsibilities was inevitable. It had to come whenever fundamental changes were made.

The growing complexity of Western civilisation traceable mainly to the applications of science—this coupled with a more general liberal education—has tended to dwarf the individual in every field of human affairs. Wherever you look, you see teams of specialists where relatively few years ago an individual man or woman devised, controlled and prosecuted to completion social, industrial and scientific operations. Our own branch of medicine has been carried along by the torrent of applied science. The M.O.H. of pre-war days was to a large extent an individualist. He had duties more extensive than any one man could cope with ; he was expected to have wider technical knowledge than one man can ever acquire. A sense of individual importance dies hard with most of us —do you recall the recent correspondence in *Public Health* in which a colleague argued in favour of the M.O.H. epidemiologist in self-sufficient dominion over an entire province—a " one-man band " another correspondent called it. The day of these things has gone. The M.O.H. had to become a member of a team in every field of endeavour with which his work brings him into contact. This had to happen to keep him in line with recent events ; and by the way, to bring him into line also with health officers in other countries comparable with our own. Regionalisation, the larger units of local government to which we are tending, and the increasing control over local affairs by central departments of state—all these things, whatever their merits, are part and parcel of the same inevitable march of events.

Is it possible, do you think, that at least a part of the disappointment we have suffered over the form of the National Health Service might be due to our failure to recognise that the teams we are interested in have become too big to have an overburdened M.O.H. as captain ? Do you not think also that the sense of frustration we have all felt recently might not be the result of an enforced preoccupation with administration for the last 20 or 30 years ? A preoccupation which often compelled M.O.H.s of the now-departed era to lose sight on occasions of their true function ?

The M.O.H. has always been aware, of course, that preventive and promotive functions were the main justification for his creation and growth. Most M.O.H.s would agree that the lightening of the heavy burden of hospital administration is a cause for self-satisfaction rather than regret, but in his recent bereavement the M.O.H. still tends to dwell too much on the memory of the adopted child he has lost, forgetting sometimes that his natural child has for long been neglected for the responsibilities of vicarious parenthood. May I recall to your minds a document which is now almost forgotten—the Ministry of Health memorandum on the duties of a M.O.H., published in 1925 ? You will remember that it begins with these words :—

" The chief function of the medical officer of health is to

* An address to the Welsh Branch, the Society of Medical Officers of Health, Friday, March 10th, 1950.

safeguard the health of the area for which he acts by such means as are at his disposal, and to advise his authority how knowledge of public health and preventive medicine can be made available and utilised for the benefit of the community. He should endeavour to acquire an accurate knowledge of the influences, social, environmental and industrial, which may operate prejudicially to health in the area, and of the agencies, official or unofficial, whose help can be invoked in amelioration of such influences. While he has special duties for the prevention of infectious diseases, all morbid conditions contributing to a high sickness rate or mortality in the area from these or other causes should be studied with a view to their prevention of control . . ."

The exposition has not lost in truth or force during the 25 years which have elapsed since it was issued. It reflects a recognition of the same fundamental need as the Act which made possible the appointment of William Henry Duncan over a century ago.

"And whereas the health of the population, especially of the poorer classes, is frequently injured by the prevalence of epidemical and other disorders, and the virulence and extent of such disorders is frequently due and owing to the existence of local causes, which are capable of removal but which have hitherto frequently escaped detection from the want of some experienced person to examine into and report upon them, it is expedient that power should be given to appoint a duly qualified medical practitioner for that purpose . . ."

It would be unfortunate if what I am about to say should lead you to believe that I fail to recognise the great opportunities and obligations for medical officers of health associated directly with the new administration.

In theory, there is provision for the complete co-ordination of the branches of the National Health Service at all levels. But most of you would agree, I think, that living links between the fragments have not yet been forged. Yet somehow the National Health Service has to be made to work smoothly as a unified whole. The M.O.H. and the department he controls have neither the powers nor resources to knit together, unaided, the health services of the country at the point that really matters—the ordinary citizen. But the M.O.H. has an indispensable contribution to make.

The efficient administration of Part III Services—"the fragments that remain"—and the development of care and aftercare services, are objectives whose mechanics need to be inspired by the understanding of medical administrators like yourselves with a nature preventive outlook. They must be firmly based on the recognition that many illnesses have social roots and social consequences; that when there is sickness in a family, domestic and nursing assistance are often needed in addition to medical care; that physicians and surgeons cannot do all that is required to restore sick persons to health. They must also be made to serve the purpose of sparing hospital beds and ensuring that the prevailing hospital-mindedness is not allowed to get out of bounds. Hospitals have a vital place in medical services, of course, but there has been a tendency to forget that patients who can be treated at home should remain at home in their own interest, to forget that the hospital is not the place for the aged and chronically sick to languish, and that it does not provide the right setting for full restoration to health and vigour after acute sickness and trauma.

The M.O.H. evidently has many immediate objectives to pursue. He must be active in the field of health education, so as to foster the idea that the personal element in disease prevention and health promotion is given a rightful place in policy making. He must develop information services to help ordinary people to use medical and social services effectively. He must act as a link between the several branches of the National Health Service, and use the powers conferred by Part III of the National Health Service to give effect to the concepts of social medicine.

There is no one at the local level, other than the M.O.H., with a complete conception of the health and medical services as a whole. It is part of his business—though not included in a schedule of his duties—to see that a proper perspective is maintained and to ensure that a balance is preserved between curative and preventive services.

Fundamental Researches for the M.O.H.

All these things are important, but I think we may take them for granted. It is not about these things that I wish to speak. I have in mind more fundamental problems to which I believe the M.O.H. has an indispensable contribution to make. I come indeed to the kernal of my remarks, which relate to researches of a fundamental kind in which M.O.H.s should participate.

I make no apology for dealing with this subject didactically. Both by training and experience you are no less qualified than I to speak with conviction on the administrative matters I have so far touched upon. But in the field of social medicine researches, I have probably enjoyed greater opportunities than most of you which have enabled me to form opinions about goals, methods and results in this field.

In a word, I am about to make a plea for the full and proper use of the existing local data for a large-scale development of local survey methods. Should you doubt the need for more precise knowledge than we possess about the wider epidemiology on which new preventive policies may be based, ask yourselves what is known with certainty of the factors which have brought about the reduced mortality from scarlet fever, whooping cough, measles, acute juvenile rheumatism and respiratory tuberculosis. Ask yourselves how much is really known about the part played by constitution on the one hand and a diversity of environmental factors on the other in coronary disease; or to what extent social inadequacy which is seen at its height in so-called problem families—to what extent the inadequacy can be ascribed to a hereditary component in different circumstances of physical environment and social life. Or if you prefer to be more practical, ask yourself what you know of the incidence and distribution of minor maladies and dis-harmonies in family and community life in your own areas, all of which exact a high price in the shape of poor general health, depressed vitality and social ineffectiveness. In the last connection, by the way, the prevention of relatively trivial maladies at all ages has now become, or so it seems to me, the legitimate purpose of local health departments. Recurrent colds, chronic catarrh, muscular pains, flat feet, corns and bunions, are among the common disorders which prevent large numbers of people from enjoying full vigour and happiness. Some are the progenitors of graver diseases and disabilities, and local government departments might do well to treat minor maladies as problems worthy of study.

Some of the problems I have mentioned can be approached by studying national statistics already in existence as was done for instance by Morris and Titmuss for peptic ulcer, Stocks for cancer, and quite recently by Ryle and Russell for coronary disease. Others lend themselves to national sampling surveys of the kind used for the continuing social Survey of Sickness, but a great many of these problems can best be undertaken through local studies. In some instances by discovering the enormous mass of data in health departments which has never seen the light of day—an analysis of the age and sex incidence of the notifiable infectious diseases, for example—but many urgent questions can best be answered by surveys and field studies planned for and executed in the areas of individual local authorities.

The outstanding need of the moment, so far as we are concerned is, I nelieve, for a number of local morbidity surveys in areas selected for the diversity of their geographical, industrial and social circumstances. And recent experiences have led me to conclude that medical officers of health are the people best fitted to prosecute researches of this kind to a successful conclusion.

As I daresay you are aware, working with Richard Titmuss —who, by the way, is the author of "Problems of Social Policy" in the official civilian histories of the war series recently published by H.M.S.O.—he and I embarked in 1945 on a study of infant morbidity in Luton which will be completed next year. It has already been the subject of published interim reports and only last month a special study of sickness in the first year of life was published by my successor in Luton, Dr. R. M. Dykes, under the title of "Illness in Infancy." I wish to refer to this work for the purpose of illustrating the far-reaching possibilities of local surveys, and

also to indicate how, to my way of thinking, the research potentialities of local health departments might be marshalled. To save time, I propose to read passages from a foreword by which I introduced Dykes' special study :—

EXTRACTS FROM FOREWORD OF "ILLNESS IN INFANCY,"*

This is not the place to anticipate the details of Dr. Dykes' paper but the main conclusions we have been able to draw from the survey and the case studies are well worth stating. In the broadest terms they amount to this :

1. The concentration of a great deal of illness in a small fraction of the population, believed to be a feature of adult age groups, is a characteristic of the first year of life.

2. Infant mortality has a social gradient but infant morbidity has not—it is evenly distributed among the social classes. That is to say, whilst the chance of an infant dying is greater in a less well-to-do than in a well-off household, the sickly or ailing infant is as common in one as in the other.

3. "Constitution" appears to be the main factor which determines the composition of the group of infants in which a great deal of, sickness is concentrated.

The conclusion about the part played by constitution was, I should say, adopted with reluctance. Looking back, it is obvious that we were prejudiced against admitting it. This, perhaps, is not astonishing for steeped, as many of us are, in a preventive outlook based largely on micro-biology, our habit of thought tends to focus attention on environment to the exclusion of diathesis, constitution or sickness-proneness—call it what you will. And probably, our minds were also resistant to the idea of a constitutional component because of prejudices fostered by inadequate interpretation of human heredity, once in common currency—interpretations which assumed far too readily the independence of heredity and environment, and often mistook defective social opportunity for genetic inferiority. Whatever the explanation, however, the constitutional hypothesis was adopted only through the compulsion of ascertained fact.

What has been found out about Luton infants may not, of course, be of great interest to Medical Officers of Health and paediatricians elsewhere, but the question "To what extent are the Luton findings true of other areas ?" must occur to every reader. We cannot answer this question ; we have not the facts. But unless I am greatly mistaken, the potentialities of local investigations are so great that it is high time such questions were tackled.

There is, of course, nothing original in this opinion. Professor John Ryle has been insisting for many years on the importance of what he calls the "social post-mortem" ; and I am sure he does not advocate only a gigantic national autopsy. Quite recently also we find the Registrar-General writing, "The corresponding measurement of sickness in relation to local populations is also important and is of particular concern and interest to Medical Officers of Health. It presents even greater difficulties, and is also being studied."

There is, then, nothing new in the idea that local morbidity surveys can be very valuable, but it is perhaps not generally realised that a number of developments will combine to make a wide range of local studies generally practicable in the near future.

At this moment, preventive medicine, and in particular Medical Officers of Health, are searching for new objectives. They are looking for techniques which will enable them to apply epidemiological concepts not only to the infectious diseases; but to the whole range of human disease—techniques which will enable them to say precisely how and where living conditions should be modified to improve the public health. Secondly, for the first time for some decades, health departments all over the country are no longer overburdened with managerial and administrative duties ; and for the first time the technology of mechanical counting methods is becoming familiar to most health officers. And thirdly, a national census in 1951 can be expected to provide statistical data for each locality, against which social and sickness surveys can be undertaken ; and moreover, a great deal of information about adult sickness is likely to be made available by the Ministry of National Insurance in the near future.

A number of local surveys would almost certainly show that in some places besides Luton there is no social gradient for infant sickness. In these places a standard of favourability of environment has been reached which makes the probability of an infant being sickly a measure, not of environmental factors, but of the stuff the infant is made of. In less favoured places, on the other hand, environmental factors might well be important determinants of infant sickness rates.

If this reasoning is sound, it follows that a great deal could be learnt from morbidity studies in a number of different areas. Suppose, for instance, that for a score of towns in different parts of the country we could ascertain the total amount of infant sickness and its distribution in component groups within each town ; and then set out these facts against the economic, housing, climatic and industrial circumstances of each town. Might we not have the means,

(*a*) of describing in fairly accurate terms the improvements which would have to be made to raise every town to the standard of the best ;

(*b*) of saying to what extent a reduction of infant sickness by general environmental improvements is practical politics ;

(*c*) of setting a limit on the improvements in sickness rates which general environmental measures can bring about—and of defining a residuum of sickness which is likely to yield only to specific measures, or to measures needed only by a fraction of the infant population which differs somehow from the generality ;

(*d*) of obtaining, in other words, a measure of the amount of infant sickness which cannot in the ordinary circumstances of life be attributed to environmental factors in the post-natal period ?

Let us go a stage further. Suppose the local survey method could be extended to adult age groups and to a variety of diseases—particularly, say, to peptic ulcer, acute rheumatism, recurrent respiratory catarrh, asthma, migraine, cardio-vascular degeneration, coronary thrombosis and the neuroses—who can tell what new lines of thought might thus be opened ? . . ."

"The aetiological problems of adult sickness will not be easy to solve, but there are good reasons for attacking them with renewed vigour now. So long as the control of epidemic diseases—cholera, plague, smallpox, typhus and more recently the enteric fevers and the common infections of childhood—so long as the control of these diseases dominated public health, the social "post-mortem" was an extravagance, a mere frill. Now it has become a necessity if preventive medicine is to fulfil its destiny . . ."

"To say this is only to re-state a truth which tends to be obscured in a rapidly changing society, but it is a truth which embodies an obvious directive to discover the facts. And I am not alone in believing that local surveys can contribute to its fulfilment . . ."

It would be premature to go into detail, but I can tell you that I am in the process of exploring ways and means of securing the collaboration of a number of M.O.s for the prosecution of local morbidity surveys of the kind I have referred to.*

Summing up

Let me conclude this somewhat discursive address by saying with all the force at my command that, in my view, there is an urgent need for M.O.H.s to justify their status as specialists in preventive medicine in the favourable hygienic and sanitary circumstances of the present day. They, and only they, combine with an enlightened preventive outlook the local knowledge required for many aetiological and epidemiological investigations, and it is hard to think of a greater contribution they could make to the advancement of preventive science. As administrators, however informed and competent they may be, they are unlikely to command the high respect of clinicians and scientists. By contributing to fundamental epidemiological knowledge, by helping to relate medical conditions and social circumstances in the modern world, they can and should make a lasting contribution to human welfare and regain the position of professional eminence which has been temporarily eclipsed. I am far too conscious of the obstacles the M.O.H. has encountered—and surmounted—in recent years, far too well aware of the disillusions he has suffered, to be adversely critical. Yet, in face of hard facts, you will forgive me for asking what signs there are that the present generation of M.O.H.s has advanced as a body to meet the challenge of new opportunities within their sight.

* "Illness in Infancy," by R. M. Dykes, with a foreword by Fred Grundy (Leagrave Press, Luton, 1950). Obtainable from the Luton Health Department, price 2s. 6d.

* A letter from Prof. Grundy on this subject appeared in the June issue of *Public Health*.

An informal conference to discuss aspects of the better co-ordination locally of home and hospital services in the sphere of mental health is to be held at the Town Hall, Salford, Lancs, on July 14th, 1950, at 2.30 p.m. Dr. Joshua Bierer, Institute of Social Psychiatry, London, will speak on the various aspects of individual and social psychiatry, such as the therapeutic social club. Dr. J. W. Affleck, of the Leeds Mental Health Services, will also speak and other mental health experts have promised to join in the discussion. All those interested are invited to attend.

WHAT IS CHILD GUIDANCE? *

By A. A. E. Newth, M.B., D.P.H.,
Senior School Medical Officer, City of Nottingham

The Handicapped Pupils and School Health Service Regulations, 1945, require local education authorities to establish a School Health Service and to appoint school medical officers to look after the health and well-being of the children.

This was not, of course, a new idea. School medical officers had been caring for the health and well-being of school children for many years. The service was established because it was found at the beginning of this century that children were not being cared for properly, and its history has been characterised by a widening of its interests as advances were made.

Sir George Newman, the Chief Medical Officer of the then Board of Education, in one of his earlier reports foreshadowed an organic development of the service and its concern in child guidance is an example of this.

The history of the child guidance movement was given in the "Health of the School Child" for 1939–45. It started with the work of Dr. William Healy on juvenile delinquents in Chicago, and spread rapidly throughout America, being introduced into England through the generosity of the Commonwealth Fund of America. Dr. Ralph Crowley, of the Board of Education, who took such a keen interest in the less fortunate children, visited America and, after carefully weighing up its merits, repeatedly recommended it to school medical officers in successive issues of the "Health of the School Child." It was taken up by Emmanuel Miller, William Moodie, and other doctors in connection with voluntary clinics, by Shrubshall and Letitia Fairfield, of the L.C.C., by Robert Hughes, S.M.O., of Stoke-on-Trent, and Auden, S.M.O., of Birmingham, and by certain mental hospital doctors such as Kimber and Evelyn Lucas. Local education authorities became interested to an increasing extent, and Circular 29 mentioned child guidance as one of the several forms of treatment to be developed to implement the requirements of the Education Act, 1944. Some educational psychologists were interested, particularly Sir Cyril Burt, Prof. Cattell, Susan Isaacs and Lucy Fildes, but the expansion of the work was due chiefly to the initiative of various medical men and women.

It is not easy to define what is meant by child guidance. Earlier reports of the Child Guidance Council said that it was primarily to advise parents—but it is more than this. Others said that it was for the elucidation of behaviour problems—but many child guidance cases show no behaviour problems. "The Health of the School Child" for 1939–45 speaks of the child who is mentally disturbed or emotionally deranged. These phrases are not very satisfying.

I myself like the term maladjusted. The tendency of a child to become maladjusted may be likened to that of a motor car engine. Certain kinds of engine may be designed for ordinary use by everyday owner-drivers; others for rough agricultural work; others again for high speed racing in the hands of skilled mechanics. Cars of any one of these classes may leave the works in perfect adjustment but will vary in their tendency to get out of adjustment. A car badly designed and constructed from poor material will break down under ordinary conditions, while those of sturdy make may work well for a long time without needing much attention, provided they are not mishandled. There are some persons who seem inherently unable to manage any mechanical contrivance without damaging it. One thing is certain—the car will run inefficiently, it will be a nuisance to its driver and possibly a danger to others, and it will suffer serious and permanent damage unless the necessary adjustments are made. Some adjustments are easy to carry out, particularly if tackled in the early stages; others call for the skilled attention of an experienced technician. The harm that may be done by the amateur or semi-efficient mechanic, is incalculable.

Children may become maladjusted to themselves, to their parents or guardians, to other children or to society. Generally the child will be found to be maladjusted in more ways than one. The symptoms are often multiple and vary from time to time. The symptom complained of in the first instance may not be the one that is causing the greatest anxiety.

For these reasons it is difficult to classify the reasons for which children are referred to a clinic, but the Child Guidance Council have suggested a classification which is useful, although of no great scientific value :—

Classification of Problems

1. Nervous Disorders :
   - i. Fears—anxiety, phobias, timidity, oversensitivity.
   - ii. Seclusiveness—unsociability, solitariness.
   - iii. Depression—brooding, melancholy periods.
   - iv. Excitability—over-activity.
   - v. Apathy—lethargy, unresponsiveness, no interests.
   - vi. Obsessions—rituals and compulsions.
2. Habit Disorders :
   - i. Speech—stammering, speech defects, aphonia.
   - ii. Sleep—night terrors, sleep-walking or talking.
   - iii. Movement—twitching, tics, head-banging, nail-biting.
   - iv. Feeding—food fads, nervous vomiting, putting things into mouth.
   - v. Excretory—enuresis, faecal incontinence.
   - vi. Nervous pains and paralysis—headaches, deafness, etc.
   - vii. Fits—epilepsy, hysterical fits, loss of memory.
   - viii. Physical—allergic disorders, asthma.
3. Behaviour Disorders :
   - i. Unmanageable—defiance, disobedience, refusal to go to work or school.
   - ii. Temper.
   - iii. Aggressiveness—bullying, destructiveness, cruelty.
   - iv. Jealous behaviour.
   - v. Demanding attention.
   - vi. Stealing—begging.
   - vii. Lying and romancing.
   - viii. Truancy—wandering, staying out late.
   - ix. Sex difficulty—masturbation, sex play, homosexuality.
4. Psychotic Behaviour—hallucinations, delusions, extreme withdrawal, bizarre symptoms, violence.
5. Educational and Vocational Difficulties :
   - i. Backwardness—mental retardation, school failure.
   - ii. Inability to concentrate—day-dreaming, inattention.
   - iii. Inability to keep jobs.
   - iv. Special disabilities—high-frequency deafness, etc.
6. For Special Examination :
   - i. Psychological examinations.
   - ii. Educational advice.
   - iii. Vocational advice.
   - iv. Court examinations.
   - v. Admission to special homes or hostels.
   - vi. Placement in foster homes.
   - vii. Adoption.
7. Unclassified.

The symptoms often bear no obvious relation to the cause of the upset and may give little indication of the seriousness of the trouble. The quiet model child may be the subject of deep-seated psychological disturbance, while another child showing distressing behaviour may be found to be suffering from only superficial disturbance.

All children behave badly or get emotionally upset from time to time and the wise parent or teacher can generally deal with the trouble successfully by symptomatic treatment. Such cases should not get to the child guidance clinic. It is only when the ordinary treatment is found to fail that the clinic need be consulted with the object of trying to find out the cause of maladjustment and to suggest a way of putting it right.

The causes of maladjustment in children are innumerable, involving social, educational, psychological, medico-psychological and medical factors interwoven very closely. So complex are these factors that it is now accepted that the work must be undertaken by a team of workers, consisting of a psychiatrist, educational psychologist and psychiatric social worker. This is the essential foundation on which child guidance was built up in America, and although individual workers have had success by other methods of approach at times it can hardly be called child guidance.

* Presidential Address to the School Health Service Group, Society of Medical Officers of Health.

Child guidance work having been started by medical pioneers in children's hospitals, general hospitals, mental hospitals, universities and the School Health Service, tended after 1936 or 1937 to be taken up more and more by education authorities through their school health services. The troubles with evacuated children and the distressing increase of juvenile delinquency gave an urge to the work although the difficulty of getting staff proved a severe handicap.

The Faversham Report

The Feversham Report on the Voluntary Mental Hospital Services published in 1939, was drawn up by a well-balanced committee of persons qualified by experience to express level-headed opinions. They advocated the appointment of educational psychologists by education authorities to advise upon backward children and difficult problems of behaviour and education. Suitable cases were to be referred to child guidance clinics for further investigation and advice. At the same time they recommended the appointment of a full- or part-time psychiatrist to whom special cases of mental defect or behaviour disorders might be referred. They considered that child guidance should be a normal service of an education authority but were insistent that the clinic should be properly staffed and should be under the charge of a psychiatrist. While they seem to have favoured the clinic being run in connection with a general hospital, they would not lay down any hard and fast rules, observing that in some districts a school clinic or welfare centre might meet all requirements. (In 1948, out of 96 clinics in England, excluding London, in one instance only the clinic was in connection with a university, one was voluntary, eight were in connection with hospitals, and 86 were local authority or county council clinics.)

The Feversham Report was followed in 1941 by the report of a committee of the B.M.A. advocating a mental health service in each authority for all mentally sick persons, the appendix containing a scheme for child guidance approved by the Child Guidance Council.

In the Supplement of the *B.M.J.* for June 16th, 1945, there appeared the plans for a psychiatric service drawn up by a joint committee of the B.M.A., the Royal College of Physicians and the Royal Psychological Society. This committee on which the mental hospital services were strongly represented, recommended the establishment of mental health services which, with appropriate statutory powers, were to be responsible for all aspects of mental health work, including child guidance, all mentally defectives, adult and children, educable or ineducable, and the curable and incurable insane. This was given an excellent press in *The Times* of June 30th, 1945.

On February 21st, 1946, Dr. Blacker published his book on "Neurosis and the Mental Health Services," with a foreword by Sir Wilson Jameson, urging the development of treatment for neurotics and borderline psychotics. Although evidence was not collected from child guidance clinics, there were some child guidance clinic personnel connected with the enquiry, and the author, a mental hospital physician, made certain recommendations as to child guidance work. Very briefly, these were to the effect that there should be child guidance *centres* under the education authorities, and child guidance or psychiatric *clinics* incorporated in the Health Service. The difference between the two types of set-ups lay in the latter being under the direction of a medical psychiatrist, whereas the former were to be under a non-medical psychologist. *The Times* of the same day had a long and important article by its medical correspondence warmly advocating the scheme; the wording of the article almost suggested that it was already a *fait accompli*.

The same idea was put forward by Sir Laurence Brock, Chairman of the Board of Control, in an article in the *Lancet* of March 6th, 1946, and received further support in 1947 in the Nuffield Provincial Hospitals' Trust Report in an appendix on the planning of hospital services in the Berks, Bucks and Oxon region.

It was not surprising that in 1945 the Association of Education Committees, whose secretary was at one time a psychologist of note, published a report giving the plans of a child guidance service as part of the education service with the educational psychologist as the key person. He or she was to have the organisation of this service and was to have on the staff a member of the school medical service and a medical psychiatrist.

It should be observed, however, that in the previous year the Council of the B.M.A. had decided to oppose the principle of psychiatrists working in clinics under the direction of lay psychologists. (Supplement of the *B.M.J.*, May 13th, 1944.)

The Society, it will be recalled, challenged this scheme of the A.E.C. very vigorously. It emphasised the "medico-psychological character of the large majority of child guidance cases in contrast to the educational. It feels that it would be as ill-advised to entrust this work and its organisation to an educational psychologist as it would be to entrust an orthopaedic scheme to a physical training inspector."

The *Lancet* of December 6th, 1947, in a leading article, stated very clearly that the Child Guidance Council was opposed to the Blacker plan. "In applying the ominous political device of partition (the scheme) depends for success on a mutual tolerance not always evident except where the working bond is close, and it presupposes among educational psychologists a state of clinical experience which seldom exists; it entrusts to untrained persons the difficult task of recognising psychiatric illness among school children, while the psychiatrist, against the trend of modern psychiatric practice, retreats once more to his clinical castle."

In July, 1948, Prof. Moncrieff, Secretary of the British Paediahic Association, and Dr. Soddy, Medical Director of the National Association for Mental Health, sent a letter to Directors of Education expressing concern at the organisation in some areas whereby a psychologist without medical qualifications could be entrusted with the ascertainment and in some cases even the diagnosis and treatment of disorders in childhood.

Ministry of Education Circular 179

In spite of these protests, the Ministry of Education in August, 1948, published its famous Circular 179, suggesting that the needs of most maladjusted children could be met by social and educational adjustments, and that consequently much of the child guidance work could be carried out in schools by educational psychologists and specially qualified social workers. Those children who were found to need psychiatric treatment should normally be referred to clinics which were to be provided in due course by the regional hospital boards, and which in some instances, were already available. At about the same time the Ministry of Health were advocating similar principles. Short-term cases were to be treated in child guidance centres of local education authorities and long-term cases in child psychiatric clinics of the regional hospital boards.

The Council of the Group were alarmed at these suggestions. In their experience, few cases responded to simple social and educational adjustments. They could not understand the distinction between long-term and short-term treatment cases; children requiring educational treatment generally needed it for a long time, whereas some seriously disturbed cases might respond rapidly to suitable psychiatric treatment by a psychiatrist. In any case, in child guidance work it was often impossible to distinguish between diagnosis and treatment, and attempts to separate the two would lead to a dichotomy which would destroy the whole basis of child guidance work. Sir Allen Daley led a deputation to the Ministry of Education, and we put our case to Mr. Marris, the Under-secretary, Dr. Rees Thomas, of the Board of Control, Dr. Underwood and others. Our sincerity carried weight. We were told that the Ministry did not want to prescribe the precise set up of the child guidance centres provided they were run on reasonable lines, and Dr. Rees Thomas said that psychiatric treatment clinics might be set up within an education authority's child guidance centre, the services of the psychiatrist being provided by the regional hospital board. Mr. Marris asked that we should try out the scheme for six months and then come back to him. This was in October, 1948.

It is difficult to make out what is happening in the child guidance world. The Child Guidance Council arranged an

Interclinic Conference in December last in an attempt to learn how things were going. The report has not yet been published, but I was left with the impression that workers had not been unduly disturbed, although there were certain aspects which were causing dissatisfaction. One of the most striking points that arose was, although that the large majority of the representatives were lay persons, opinion was practically unanimous in wanting the work to be under the control of doctors.

Form 2 H.P.

This came as somewhat of a surprise to some of us because there had been reason to fear that we doctors had been losing the confidence of laymen in respect of psychological work. The A.E.C. scheme tried to delegate doctors to the position of assistants to educational psychologists. Circular 146 of the Ministry of Education, published in June, 1947, gave timely warning about the selection of school medical officers for duties in connection with educationally subnormal children, but it provoked educational psychologists to claim greater share in the completion of Form 2 H.P., the suggestion being that they were more capable of doing this than medical officers, with the result that a new form had to be drawn up. At the British Association meeting in 1948 Prof. Rex Knight claimed that Burt's Young Delinquent was the *fons et origo* of child guidance in this country, and he omitted to mention the medical pioneers. Prof. Valentine took the opportunity of his presidential address to the British Medico-Psychological Society (*British Journal of Educational Psychology*, November, 1948) to attack doctors as advisers in children's psychology. Sir Cyril Burt, in the issue of the same journal of February, 1949, laid about him with even greater vigour, attacking not only school medical officers, but even Freud himself—a remarkable article well worth reading, but a surprising one from a psychologist of the standing of the author.

It must be acknowledged that the ordinary curriculum of the medical student does not encourage great interest in psychiatry or psychology, and many doctors start their careers with a greater faith in the physical than in the psychological aspects of medicine. Some retain this attitude and not a few doctors look upon child guidance with suspicion and even tend to build up a sort of cordon sanitaire round the psychiatrist. At the Interclinic Conference already referred to, some of the delegates alleged with some bitterness that certain administrative school medical officers assumed the responsibility of diverting cases from the child guidance clinic without taking any intimate part in the work of the clinic.

The Child Guidance Team

Nevertheless, there is no doubt that the medical training affords an essential foundation upon which further education in psychological medicine can be built if the doctor happens to be attracted to this branch of his profession. No one would entrust the medico-psychological problems of adults to anyone but a medical man, and although the psychological difficulties of children may differ in certain important respects from those of adults, no one with an intimate knowledge of child guidance work would entrust the supervision of the cases to other than a medical man.

On the other hand, a training in psychological medicine does not necessarily fit a doctor to understand the maladjustments of children, and it is essential that the child guidance doctor should have special training in child psychiatry. In addition, he should have a lively interest in the work of the schools and of the school health service.

In order to conserve the time of the psychiatrist for his technical work, a school medical officer of senior rank with a special interest in child guidance might well be entrusted with the administration of the clinic. He should also act as physician to the centre. In this way it would be possible to ensure the necessary liaison between the physical and psychological aspects of the work.

The other members of the team, the educational psychologist and the psychiatric social worker, will fall naturally into their places, supplying their own highly valuable technical help to the team which is the true basis of child guidance work. Each member of the team, if fully trained, will have sufficient faith in the importance of his own line of approach to urge him to follow it faithfully and not to impinge on the work of his colleagues, although to a varying degree according to the nature of the particular case under discussion any one member may take a more predominant place. A team must have a leader and it will be for the psychiatrist, after considering the various reports in consultation with his colleagues at the case conference, to give cohesion to the various reports. He should be able to command their confidence while at the same time he should be willing to hand over to them for further action such aspects of the work that may seem advisable.

With regard to the qualifications of the various members of the team, it is obvious that they should have had adequate training and experience. For some months my authority has been trying to get an educational psychologist to replace one who on marriage was unable to give enough time to the work, and I have been amazed at the number of people who consider themselves capable of undertaking this branch of the work although not possessing suitable qualifications or experience. It is to be hoped that education authorities will not be tempted to make unsuitable appointments in their anxiety to complete their staffs and that each professional body concerned will do its best to maintain a high standard of efficiency amongst its members so that its work does not fall into disrepute.

From time to time one reads of comparisons being made between child guidance clinics run by the school health service, by childrens' hospitals or the childrens' departments of general hospitals or by mental hospitals. Some years ago the Child Guidance Council was strongly in favour of the voluntary clinics and opposed to the idea of clinics run by local education authorities, but by 1938 they had modified its ideas very considerably and, as already mentioned, in 1947 it expressed itself definitely in favour of the clinic run by the school health service of the L.E.A.

This is gratifying to the school medical officer, and he could adduce many reasons for showing the wisdom of the change of policy. Nevertheless, when he attends interclinic conferences he finds that workers in other types of clinics are equally convinced of the soundness of their own organisations and are sceptical about the efficiency of others. No doubt the truth is that different types of clinics have somewhat different aims and are probably dealing with a somewhat different type of maladjusted children.

It is difficult to prove this statistically, because, unfortunately, various clinics report on their cases under differing classifications, but Tables I, II and III, drawn up from figures given in reports of certain clinics, support this view.

A — L.E.A. clinic of a large county borough in the Midlands.
B — L.E.A. clinic of a county council in the Midlands. (A and B have the same psychiatrist although they are run quite separately.)
C — Clinic of a mental health authority of a large county borough.
D — Clinic of a large children's hospital in London.
E — L.E.A. clinic of a large C.B. in the Midlands. In 1941 it was under a part-time psychiatrist. There was a change in the organisation between then and 1943 when it was under the educational psychologist.
F — Clinic of the children's department of a county hospital.

TABLE I

CLASSIFICATION OF CASES. 1948

Nature of cases	A	B	C	D
Nervous	25·4	19·3	11·0	7·2
Habit	29·4	21·0	20·4	39·9
Behaviour	29·7	26·1	24·7	23·5
Psychotic behaviour	1·0	—	0·3	2·0
Educational and vocational ...	6·0	11·8	10·7	20·8
Special : Court cases, etc. ...	7·3	21·8	32·5	3·4
Other	1·0	—	0·3	3·3
Number of cases	299	238	308	446

In A, the children's hospital has its own psychiatrist. Also, the educational and vocational cases do not include 275 cases examined by the educational psychologist—secondary school placements, non-readers for educational therapy, and partially-deaf and partially-sighted pupils.

TABLE II
CLASSIFICATION OF CASES IN E

Nature of cases	1941	1943	1948
Nervous	13·8	7·3	12·6
Habit	9·0	3·7	7·4
Behaviour and court cases ...	49·5	30·3	36·1
Intellectual	27·7	55·5	43·5
Other	0·0	3·1	0·4
Number of cases	99	193	269

" Intellectual difficulties " comprise educational retardation, special disabilities and educational guidance.

The shifting of interest to the intellectual when the clinic came under the organisation of the educational psychologist is very clear.

TABLE III
SOURCES OF REFERRAL. 1948

Referred from	A	B	C	F
School	31·0	14·7	14·6	15·0
Parent	9·0	7·5	13·6	—
School M.O.	21·0	27·8	14·6	—
Private doctor	13·0	11·3	12·0	64·0
Hospital	*	—	2·6	17·0
Clinic staff	7·0	—	6·5	—
Probation officer and S.A.D.	12·0	21·4	33·4	4·0
Others	7·0	17·2	2·6	—
Number of cases	299	238	308	100

* Local children's hospital has its own psychiatrist. It is known that in A and B the referrals classed under " school " came often in the first place from the parent who had asked the head teacher to refer the case to the child guidance clinics.

With regard to court cases, in area A there is close co-operation with the probation officer, the S.A.D. and the children's officer; information is given about a large number of cases before the case comes into court and full child guidance examination is done only when essential.

There is no doubt that many of the difficulties met with in later childhood can be traced back to causative factors dating from very early years. Melanie Klein has shown that it is possible to apply psychoanalytic methods to very young children, and Bowlby, in his book " Forty-Four Juvenile Thieves," lays stress on affectionless children and claims that their condition can be diagnosed at three years of age. It is tempting, therefore, to envy the children's hospital which seems to get hold of cases much earlier than the school health service clinic as is shown in Table IV :—

TABLE IV
PERCENTAGE OF CASES IN AGE GROUPS
(Children up to 12 years of age only)

Clinic	Under 2 years	2–4 years	5–6 years	7–12 years	Cases
C.B. school health clinic. A ...	—	9·0	13·5	77·5	250
" " E ...	—	5·0	19·0	76·0	216
Children's Hospital, London. D	4·0	34·0	23·0	39·0	?

Tables I and II have shown that the children's hospital deals with a higher proportion of habit cases as might be expected. We do not know whether the treatment of these habit disorders results in less behaviour troubles in later years. Those of us who have been accustomed to deal with somewhat older children may wonder how much can be done at such early ages unless the behaviour is causing great anxiety or unless the home factors are such as to be amenable to adjustment. My own experience has been that not a few of the very young ones referred to have been almost certainly of low intelligence, while others could be dealt with satisfactorily by the simple expedient of admission to a nursery class. Some, however, have been important cases and there is no doubt that although we may feel that there is plenty of material in the schools to keep the clinic staff busy, we should be always prepared to give help to children of all ages when called upon to do so. The Education Act gives power, in fact a duty, to deal with maladjusted children whether at school or not from the age of two years.

Delinquents

Somewhat at the other end of the scale are the delinquents. It has been frequently recommended that all child delinquents should be submitted to child guidance examination, and it may be pleasant to probation and children's officers to be able to present a full report from a child guidance clinic. But it is time-consuming work and unless we feel that we have useful advice to give we may be wise to conserve our limited strength to more promising work. It is not every magistrate who wishes to hear the views of the psychiatrist and his colleagues, but I have found it to be acceptable when it is given circumspectly—clearly and authoritatively, with all deference to the prestige of the court. It is important that probation officers and children's officers should understand the approach of the child guidance clinic so that magistrates are advised by them not to put upon the clinic impossible tasks such as the treatment of quite unsuitable cases or making treatment at a clinic a condition of probation.

I do not propose to say much about treatment because this I believe to be highly technical work to be arranged or carried out by the psychiatrist himself. If treatment of the child is entrusted to a lay psychotherapist the latter should be allowed to carry on without interference but with the knowledge that when unusual difficulty is experienced the psychiatrist is ready to give advice.

Treatment—Home or Hospital ?

Whenever possible treatment should be carried out while the child is living in his own home, but there are certain cases in which transfer to a hostel is essential. This question of hostel treatment is a big one and I shall confine myself to observing that residence in a hostel is a form of medical treatment to be reserved for those who are definitely in need of it and able to benefit from it. Admissions and discharges and the conduct of the hostel are medical matters over which the psychiatrist should have clear control, supported by the school medical officer acting as a liaison with the lay education officer who is ultimately responsible to the authority. A firm stand should be taken against the hostel being used as a mere dumping ground for children who are a nuisance elsewhere or as a hotel for the temporary accommodation of normal or delinquent children. The flow of admissions should be regulated according to the capabilities of the staff to absorb them, and committees should not interfere when, owing to shortage of staff or other difficulties, the number of cases has to be cut down resulting in an alarming but unavoidable excess of overhead charges. The rushing of fences to please committees may lead to chaos and may prove as harmful as the admission of a case of infectious disease to the ordinary ward of a hospital. I have had no experience of day schools or classes for maladjusted children, but have found certain selected cases to do well in special boarding schools for difficult children.

It should be part of the ordinary work of the authority, preferably with the close co-operation of the school medical officer, to see that suitable educational placement is effected for every child. Those with severe educational subnormality should have been transferred to day or residential special school and should not reach the child guidance clinic. Less seriously retarded children should already have been put in

special classes if of appropriate ages. There may be, however, a certain number of intelligent children with specific educational difficulties for whom educational therapy with or without other psychotherapeutic treatment may be given in the child guidance clinic or in other centres throughout the area. By such means the educational psychologist may give invaluable help to many children, but in my experience the transfer of maladjusted children from one school to another because of alleged difficulties with the staff or other children has been generally embarrassing and seldom effective.

The psychiatric social worker can often give the most valuable guidance to the parent which may alter the whole aspect of the case, but too often little can be done except to support the parent through difficult times. Some parents benefit by individual help and others by group discussions during which the parents seem to help one another with only the most superficial guidance and from the psychiatric social worker. Patently neurotic or borderline psychotic parents should be referred to the mental hospital physician with the concurrence of the private doctor.

There may be many ways of treating maladjusted children, but not all are accepted by the parents or children and in any case owing to shortage of trained workers the waiting lists seem always hopelessly long. Fortunately, nature is often kind to us, and it is found that a number of the cases settle down without any very special treatment. It is sometimes difficult to understand how this occurs, but perhaps it is that we have presented to the child the parent and the teacher a different aspect of the case and they have found for themselves a way of tackling the difficulty.

No paper on child guidance should be completed without paying a tribute to the teachers. Their influence for good is enormous, second only to that of the mother. But they work under very different conditions with their large classes and necessarily pedagogic approach. It would be no more possible or desirable for teachers to deal with a case on child guidance lines than it would be for a member of the child guidance staff to take a class in school, but close co-operation of the child guidance worker with the teacher will result in the greatest benefit to the mother and child.

The private doctor is unfortunately too often so preoccupied with the physical troubles of his patients that he has little time to go into the psychological difficulties of the family. But he is generally well aware of them and possesses a more intimate knowledge of family circumstances than the child guidance worker, and I have found him to be most co-operative when he realises what we are trying to do. Unless for any reason the parent expressively forbids the child guidance staff to communicate with the private doctor, I consider it is my duty to let him have a report on the case whether he has referred to it or not.

Child guidance work is expensive and it is not unreasonable for committees to ask occasionally whether it is worth while. I doubt if it is possible to show the results of the work statistically. I am not sure even whether it is wise to quote the occasional dramatically successful case. Personally, when thus challenged, I quote some particularly difficult and pathetic case and ask what alternative treatment is possible. This will generally result in the sound commomsense of the committee overriding querrulous criticism. Under no circumstances should we be tempted to produce over-optimistic reports which may be most misleading.

Conclusion

In conclusion, I would remind you again of our duty to to help the education authority to care for the health and well-being of the children. The school health service can no more escape its obligations towards psychological health than it can towards physical health. It is difficult work with far too many failures and too few complete successes, but it is indispensable and calls for all the skill and acumen which the school medical officer should possess. To be effective we must maintain a keen and balanced outlook and thus keep this new activity at a high level and ensure the greatest assistance to the children.

OBITUARY

ROBERT MENZIES GALLOWAY, M.D. (EDIN.), D.P.H.

We announce with deep regret that Dr. R. M. Galloway, Medical Officer of Health of the County Borough of Bolton since 1932, died at the Townleys Hospital on Monday, June 5th, 1950, at the early age of 51, after a long illness from which it was recently hoped that he was recovering. We are indebted to Drs. John Yule and V. T. Thierens, and Mr. H. Moorhouse, his chief clerk, for the following tribute :—

Born in Birkenhead, he received his early education in England but went to Edinburgh for his medical education, whence he graduated with honours in 1920, after a distinguished academic career interrupted by service as a surgeon probationer in the First World War.

He spent his first five post-graduate years in various hospital appointments and thus laid a solid foundation for his future career. He took his D.P.H. in Manchester in 1923, and two years later proceeded to his M.D. with commendation at Edinburgh.

Possessed of a broad humanitarian outlook, it was not surprising that Galloway should devote himself to Public Health. His apprenticeship in that service was by way of assistant posts in Bolton and with the Lancashire County Council under two pioneers, the late Paget Moffat and Butterworth. In 1929 he became Medical Officer of Health of Dewsbury, and at the commencement of 1932 proceeded to Bolton as medical officer of health. He was a sound doctor and at the same time an administrator of no mean ability and acumen. For these reasons, quite apart from his worth as a man, he was held in the highest esteem not only by his authority but also by his colleagues and those members of the Public Health Service who were privileged to enjoy his friendship. His fondness for children and young people found expression in his work for the Bolton Lads' Club, of which he was a member of the committee and honorary medical advisor.

He had received many honours in Public Health. He was a Fellow and Examiner of the Royal Sanitary Institute, of which body he was also a Member of the Council. He was a Fellow of the Society of Medical Officers of Health and had been President of the North-Western Branch. Only last year, as President of the County Borough Group, he met his fellow members in a delightful and memorable week-end at Windermere. As recently as 1948 he was appointed Lecturer in Public Health at Manchester University.

The influence of his education in Scotland, where he spent many of his early holidays, was reflected in a pawky yet kindly and whimsical humour. As a raconteur, he was in great demand. His intimate knowledge and understanding of his fellow men could be expressed with equal fluency in the Lancashire dialect, broad Scots, Welsh or even Irish.

Both as a man and as an outstanding medical officer of health, he will be mourned by all, particularly so by his widow and four children, to whom our deepest sympathy goes out in their grievous loss. His elder daughter is due to qualify soon at Edinburgh while his elder son is in his second year at Cambridge. We know that it would have brought great joy and pride had he been permitted to see two of his children at least in the profession to which he had devoted his life. It was not to be. He has passed beyond our ken to the bourne from which no traveller returns, but we shall ever treasure his memory.

Another friend writes :—

"As one of the Society's deputation to the Ministry of Health which led to the ultimate passing of the Nurseries and Child-Minders Regulation Act, 1948, I was particularly impressed by the humane, forceful yet courteous way in which Galloway made the case for some power of control over the private enterprise nurseries being run by industry, especially in this area, sometimes to the detriment of the children. In doing so he seemed to me to show the very qualities that a medical officer of health should possess—a sense of proportion tempered with vigilance for the health of his population."

BENJAMIN ALFRED PETERS, B.A., M.D., CANTAB., D.P.H.

The death of Dr. B. A. Peters was briefly reported in our last issue. He was born in 1885 and after graduating M.B., Ch.B., Cambridge, in 1910, he was appointed R.M.O. to Park Hill City Hospital, Liverpool. After service in the R.A.M.C. in the first war he joined the staff of Ham Green Hospital, Bristol, where he spent 28 years of his professional life and built up a national reputation in fevers. He was awarded the Welch Prize of the Society for the most original contribution to meetings of Branches in the session 1939-40, *viz.*, his address " Some Unproven Assumptions in Epidemiology " published in *Public Health*, July, 1949, p. 215. His study of cross-infection over 40 years, which appeared in our contemporary *The Medical Officer* in 1946, was another typical contribution from his experience. He was a Fellow of the Society from 1911 and a well-

known figure in the West of England Branch and Fever Hospital Group; and was Lecturer in Infectious Diseases in the University of Bristol. On his retirement in 1948 he received tributes from the Lord Mayor and Corporation of Bristol and his administrative chief, Prof. R. H. Parry, has said of him that he was one of the finest clinicians in this country in the diagnosis and treatment of infectious disease and a most delightful companion, cultured and kindly.

BOOK REVIEWS

Practical Statistics in Health and Medical Work. By RUTH RICE PUFFER, D.P.H. (Pp. 238. Price ———.) New York, Toronto and London: McGraw-Hill Book Company, Inc. 1950.

Surveys and field researches depending on statistical procedures have only comparatively recently become generally accepted features of public health practice at the local level; and it is not astonishing that most of us who belong to past generations of students have had to teach ourselves for the most part, as best we could, how to apply the new statistical techniques. This has not been a bad thing because there is no way of acquiring ease and sound judgment in handling numerical data than by getting the feel of the material in the course of practical exercises. General principles, rules of practice and examples can, however, shorten laborious processes, and any book which clarifies statistical methods as applied to practical health administration is welcome.

Dr. Puffer's book is backed by wide practical experience in the statistical service of the Tennessee Department of Public Health (U.S.); and by many contacts with academic public health in the U.S.A. Some of the chapters in this book are too elementary to be needed by medical officers of health in this country—a chapter on the Value and Uses of Statistical Data, for instance—though probably most readers familiar with the subject matter would regard it as a useful summary. Other chapters dealing with methods of planning surveys and experiments will be helpful to most of us, containing as they do a wealth of practical suggestions which cannot be repeated too often. A plea for collaboration between medical officers and statisticians in advance of deciding the form of records or embarking upon elaborate investigations for which statistical analyses will be required, is given time and again in this book; sometimes directly, sometimes obliquely. It is typical of the experienced practical approach to a practical subject. Chapters on methods of handling statistical data, presentation of data and elementary statistical method—all clearly presented—are followed by chapters illustrating uses of statistical methods in the U.S. In some matters of detail these chapters are necessarily less relevant to our own problems than would be the chapters of a book written primarily for English readers. Nevertheless, they afford cogent illustrations of principles which are the same the world over.

There are few public health workers who would not find Dr. Puffer's latest contribution both profitable and interesting—for as Dr. Hugo Meunch writes in a short, though thought-provoking preface, "it is that kind of book." From cover to cover, indeed, the book is typical of its author—clear thinking, forceful, painstaking, reflecting a wide range of experience and interest, and above all a deep understanding of the problem of securing the best working arrangements as between statistical officers and medical officers in the public health service.

Manual of Hygiene and Public Health. By J. L. DAS, L.M.S., D.P.H., Professor of Hygiene and Public Health, Medical College, Calcutta (Vols. 1 and 2. Price 22s.) Calcutta: R. G. Kar, Das Gupta & Co.

The success of a book depends largely upon its standard of production and presentation. A novel, which is well printed on good paper, with an attractive binding and cover, is more likely to be appreciated than one which is shoddy. The fact is applicable to medical publications even more so. In this country we have been brought up to expect our medical literature to be well printed, bound and illustrated. Dr. Das has failed to realise this principle and has allowed his work to be published poorly bound, crudely illustrated and with the lines of print not even parallel to the margin.

Dr. Das has put into his book his personal experience of almost 40 years in public health. As his sphere of operations was mostly India, these volumes are of primary interest to members of the medical profession working there. To the European, the chapters on nutrition and food, with special reference to Indian foods, will be of value.

The information is imparted by language and illustrations probably more suited to Indian readers than students in our country. The latter, seeking enlightenment upon public health matters, other than those pertaining to India, would be well advised to read other textbooks.

SOCIETY OF MEDICAL OFFICERS OF HEALTH

COUNCIL MEETING

A meeting of the Council of the Society was held in the Hastings Hall, Tavistock House, W.C.1, on Friday, May 19th, 1950, at 10 a.m.

89. The Chairman of Council (Sir Allen Daley) presided, and there were also present the President (Dr. H. C. Maurice Williams), Drs. W. Alcock, H. L. Barker, Mr. J. V. Bingay, L.D.S., Drs. C. Fraser Brockington, C. Metcalfe Brown, George Buchan, J. S. G. Burnett, George Chesney, H. M. Cohen, F. M. Day, Sir George Elliston, Drs. James Fenton, Miriam Florentin, J. M. Gibson, F. Gray, F. Hall, K. M. Hart, G. Hamilton Hogben, J. A. Ireland, Prof. J. Johnston Jervis, Drs. R. H. H. Jolly, John Maddison, Alexander Morrison, G. A. W. Neill, A. A. E. Newth, Wyndham Parker, R. C. M. Pearson, J. Riddell, T. Ruddock-West, Mr. A. Gordon Taylor, L.D.S., Drs. J. A. Stirling, W. S. Walton, Nora I. Wattie and Anne Mower White.

90. *Apologies for absence were received from* Drs. H. D. Chalke, W. G. Clark, R. H. G. Hector Denham, Prof. W. M. Frazer, Drs. G. M. Frizelle, A. S. Hebblethwaite, C. Herington, Maurice Mitman, Prof. R. H. Parry, Drs. J. A. Struthers, G. McKim Thomas, and J. Greenwood Wilson.

91. *Minutes of the Meeting held on February 17th*, 1950 (*Public Health*, April, pages 135 to 137) were confirmed and signed.

92. *Group Grants.*—The Honorary Treasurer reported that he had consulted with representatives of the various Groups of the Society on the question of suggested amendments to the rules governing the payment of Group grants. As a result of these consultations, he recommended that in future a lump sum payment of £5 per annum should be paid to all Groups, except the Dental Group, as at present, and that instead of the *per capita* payment of 2s. 6d. per head of Group membership, a lump sum equivalent to 2s. 6d. for each of the members of the Society whose subscription was fully paid and who belonged to a Group (and who were not members of the Dental Officers Group) should be allocated for Group grants, this sum to be divided amongst the Groups (except the Dental Officers' Group) in the ratio of their total memberships, the Dental Officers' Group to continue to receive a grant of 5s. per head of the total Group membership under the 1920 agreement with the School Dentists' Society.

In addition, a further amount should be allocated to enable a minimum grant of £12 to be paid to any Group.

The Honorary Treasurer's recommendation was adopted.

93. *Rubella* (G.P. *Min.* 21).—The Executive Secretary reported that he had had further correspondence with the Ministry of Health with regard to the investigation of the alleged relationship between rubella in pregnant women and subsequent congenital defects in the children. The Ministry of Health had requested the Society to send out a circular letter to the medical officers of health of local health authorities in England and Wales to launch the investigation. The Ministry of Health would themselves deal with any subsequent correspondence. A draft of the proposed letter was before the meeting and it was agreed to co-operate with the Ministry in the manner suggested.

94. *Report of the General Purposes Committee.*—Dr. J. M. Gibson, Chairman, presented the minutes of the meeting which was held on April 21st, 1950 (Appendix A.) Subject to the following comments and amendments, the recommendations of the Committee were adopted:—

Min. 47. The Executive Secretary reported that the printers had reimbursed the Society for the cost of postage involved in sending out circulars to members of the Society necessitated by the lateness of delivery of the April issue of *Public Health*.

Min. 49. *Whitley Medical Functional Council.*—Dr. C. Metcalfe Brown made a statement on the present position of negotiations in Committee C of the Whitley Medical Functional Council. The second meeting of the Committee had been postponed and was now to be held on Thursday, May 25th.

Min. 50. *Dental Whitley Functional Council.*—Mr. J. V. Bingay informed the Council that in spite of the decision of the B.D.A. to withdraw from the proposed Dental Whitley Functional Council agreement had now been reached with the Ministry and L. A. Associations for the formation of a negotiating body to deal with Public Health Dental Officers' salaries and the first meeting would be held in the near future, probably on June 8th or 9th.

Min. 51. *British Medical Guild.*—The Executive Secretary reported that the Public Health Service Defence Trust was about to be set up and that details would appear in the June issue of *Public Health* giving the necessary information to members of the Society.

Min. 54. *Smallpox Consultants.*—It was reported that, owing to lack of time, the question of the calling of smallpox consultants was not considered at the joint meeting of the Executive Committees of the County District and County M.O.H. Group recently held at Eastbourne but that consideration of the question would be given in the near future.

Min. 57. *Child Guidance.*—It was reported that arrangements were being made for a meeting between representatives of the Public Health and Ethical Committees of the B.M.A., the Society, the Association of Education Committees and the Ministry of Education to discuss the question of Child Guidance. Dr. A. A. E. Newth would attend the meeting as the Society's representative.

Min. 58. *Industrial Health Services.*—It was reported that the Planning Sub-Committee of the B.M.A.s Occupational Health Committee had invited the Society to send representatives to discuss the Society's evidence submitted to the Dale Committee. The meeting had been held on May 4th and had been attended by the President, Sir Allen Daley, Dr. J. Greenwood Wilson and the Executive Secretary. There had been an amicable and interesting discussion on the evidence and at the suggestion of Dr. Donald Stewart, Chairman of the B.M.A. Committee, it was agreed to meet again after the issue of the Dale Report to discuss this matter further.

Min. 66. *International Public Health Association.*—The question of the formation of an International Public Health Association was considered and the difficulty of obtaining adequate continuing financial support was stressed. The President and Chairman of Council were asked to consider the matter and to advise the Council thereon.

Min. 67. *Edible Gelatin and Arsenic in Food.*—It was reported that the Standing Sub-Committee had no observations to make on the recommendations for statutory standards for edible gelatin. On the question of the introduction of statutory limits for arsenic in food, the following comments have been forwarded to the Ministry of Food :—

> "It is felt that the Committee's suggestion that 'there should be no prohibition of the sale of fresh or processed sea fish, crustacea and shell fish containing arsenic in excess of 1·0 p.p.m., if it can be shown that such arsenic is natural to the fish,' should be extended to include the meat of whales. Whales are not fish but normally feed on crustacea, krill, etc., which may have a high arsenic content. In view of the increased consumption of whale meat it would be invidious to omit it from the suggestion under review."

Min. 71. *Subscriptions to the B.M.A.*—It was reported that the Public Health Committee of the B.M.A. had been advised that it was not at present desired to seek any special concessions for Public Health Service members but rather to concentrate on the improvement of their remuneration.

Min. 74. Dr. Gibson stated that the joint committee of the B.M.A. Public Health Committee and the N.V.M.A. had considered the evidence to be submitted by them to the Interdepartmental Committee on Meat Inspection and had agreed to advise the Ministry of Food that Memorandum 62/Foods should be re-issued by regulation, thus giving it statutory force.

Min. 77. *Foot Health Educational Bureau.*—It was reported that the M. & C.W. Group was arranging a meeting at the Central Hall during the holding of the National Foot Health Exhibition to be addressed by Mr. Denis Browne, F.R.C.S. (Surgeon, Hospital for Sick Children, Great Ormond Street) on the types of foot conditions in children requiring orthopaedic advice, on Wednesday, June 14th, at 3.45 p.m., to be followed by a demonstration of shoe fitting. It was hoped that any member of the Society who was interested would attend the meeting.

Min. 78. *Purchase Tax on Gas Water Heaters.*—It was resolved that consideration of this paragraph be referred back to the General Purposes Committee for further consideration.

Min. 84. *Election of Public Health Service Representatives.*—Dr. Fenton had asked to be excused from attending the Annual Representative Meeting of the B.M.A. and Dr. F. Hall was nominated to attend in his stead.

Min. 85 *and* 86.—*Legal Standards for Disinfectants and General Nursing Council.*—These two paragraphs were referred back to the General Purposes Committee for further consideration.

Min. 88. *Banking Account.*—It was resolved that the Westminster Bank, Ltd., be and is hereby appointed the Bankers of the Society. That the said Bank be and is hereby instructed and authorised to honour the signature of the Honorary Treasurer of the Society for the time being to all cheques, bills and other documents drawn or made payable with the Bank, and to any order to withdraw any or all Securities, Short Bills, or other property in the hands of the Bank, including Box or Boxes and their contents, and that the Bank be and is authorised and requested to act on the same signature in arranging or granting credits or guarantees at home or abroad to or for the Society and under its responsibility.

That the signature of the Honorary Treasurer or Executive Secretary on behalf of the Society shall be sufficient for the endorsement of negotiable instruments paid in to the said account for collection or discounted or negotiated with the Bank. That the Bank be and is authorised to honour the signature of any other officials of the Society in place of the Secretary on notice signed by the Honorary Treasurer being given to the Bank of his authority to sign.

That a Petty Cash account be opened in the name of the Society to be credited at four-weekly intervals with the sum of £100 from the main account, the account to be operated by the Executive Secretary, Mr. G. L. C. Elliston.

95. *Officers of the Society for Session* 1950–51

(*a*) *President.*—It was reported that only one nomination for the presidency of the Society for the Session 1950/51 had been received. The Yorkshire Branch, supported by the North-Western Branch, had submitted the name of Dr. J. M. Gibson. It was unanimously resolved that the nomination of Dr. J. M. Gibson, Medical Officer of Health, Huddersfield, should be submitted for election at the Ordinary Meeting to follow. He was warmly congratulated by the Chairman, Drs. Metcalfe Brown and George Chesney and Prof. J. J. Jervis on behalf of the Council.

Dr. Gibson thanked the meeting for submission of his name.

(*b*) The following officers for the Session 1950–51 were elected under Article 18 :—

(1) Chairman of Council—Sir Allen Daley.

(2) Three Vice-Presidents—Dr. H. C. Maurice Williams, Prof. R. H. Parry and Dr. F. Hall.

(3) Honorary Treasurer—Dr. James Fenton.

Sir Allen Daley thanked the Council for his appointment for a further period and asked that consideration should be given to the appointment of his successor possibly after his next term of office and certainly after the one following.

96. *Relations between the Public Health Service and other Parts of the N.H.S.*—It was reported that at the joint meeting of the County Borough and County M.O.H. Groups held at Eastbourne on April 26th, a resolution had been passed urging the Council of the Society to appoint a committee to consider the relations between the public health service and other parts of the N.H.S. It was resolved that a special committee be appointed to examine and report, not later than August 31st, on the present relations between :—

> (*a*) Local Health Authorities and the Hospital Service, with particular reference to the liaison arrangements in the various regions ;
>
> (*b*) Local Authorities and Government departments and agencies, *e.g.*, Public Health Laboratory Service ;
>
> (*c*) Local Health Authorities and Local Executive Councils ;
>
> (*d*) Public Health departments of Local Authorities and other local departments, *e.g.*, Social Welfare and Children's departments ;

and to make recommendations. The special committee to include the President (Dr. H. C. Maurice Williams), the President elect (Dr. J. M. Gibson), the Chairman of the General Purposes Committee when appointed ; the Chairman of Council (Sir Allen Daley), Prof. R. H. Parry, Dr. F. Hall, Dr. J. A. Stirling, Dr. F. M. Day, and two members each to be appointed by the County Borough and County M.O.H. Groups, the committee to have power to co-opt further members.

97. *Honorary Fellowship.*—It was unanimously resolved that Sir Wilson Jameson, formerly Chief Medical Officer, Ministries of Health and Education, be nominated as Honorary Fellow of the Society. It was further resolved that the officers should consider the question of a suitable occasion at which to present the honour to Sir Wilson.

98. *Salary Scales of Public Health Nurses.*—The following resolution passed by the Committee of the Women Public Health Officer's Association was received :—

> "This meeting deplores the very long delay in the promised revision of salary scales of women public health officers, especially in view of the settlements already reached for some grades of nurses in institutions. In view of the enhanced cost of accommodation and other increased living expenses which health visitors as non-resident workers have to bear, and of the extra qualifications which they are required to hold, this meeting is of the opinion that this long delay in the revision of salaries constitutes a grave injustice and urges that all possible steps be taken to press the gravity of the situation on the Whitley Council and the departments concerned with the Public Health Service."

It was resolved to reconsider the matter when a decision had been reached by the Nurses and Midwives Whitley Council, following the recent direction by the Industrial Court.

99. *Committee on Internal Administration of Hospitals.*—The membership of the Committee appointed by the Central Health Services Council to study the internal administration of hospitals was reported. It was also reported that invitations had been sent out to various Societies to submit evidence to the Committee but the name of the Society had not been included. A press notice had, however, been issued stating that Societies wishing to submit evidence were to inform the Secretary. It was resolved that the Society submit evidence to the Committee and that the President, the President-elect, the Chairman of Council, Drs. C. Fraser Brockington and Maurice Mitman be appointed to consider the evidence to be

submitted and to make recommendations to the Provincial meeting to be held at Southampton on July 7th.

100. *Representation of the Society.*—It was resolved that the following members be appointed to represent the Society at the conferences mentioned :—

(*a*) *National Smoke Abatement Society.*—Annual Conference, Margate, September 27th to 29th.—Dr. J. S. G. Burnett.

(*b*) *Royal Sanitary Association of Scotland*—Annual Conference, Rothesay, September 12th to 15th.—President Dr. H. C. Maurice Williams.

(*c*) An invitation was received from the Mental Health Research Fund for a representative of the Society to serve on the Fund's Committee. It was resolved that no action be taken on this invitation.

101. *Recommendations for Fully-paid Life Membership.* — The following recommendations for life membership from the following Branches were confirmed for presentation at the Ordinary Meeting of the Society to follow :—

Home Counties Branch

Dr. R. P. Garrow (formerly M.O.H., Hornsey). Joined the Society 1920.

Northern Ireland Branch

Dr. J. Gillespie, (formerly Chest Physician, County Down). Joined the Society 1910.

North-Western Branch

Dr. Catharine L. Corbett (formerly A.S.M.O., Lancs). Joined the Society 1908.

Dr. R. R. Duncan (formerly M.O.H., Altrincham U.D.). Joined the Society 1923.

Dr. R. Gamlin (formerly Senior Assistant S.M.O., Liverpool). Joined the Society 1918.

Yorkshire Branch

Dr. R. Cattley (formerly M.O.H., York). Joined the Society 1897.

There being no other business, the meeting terminated at 11.55 a.m.

Appendix A

GENERAL PURPOSES COMMITTEE

A meeting of the Committe was held in Committee Room B, Tavistock House, W.C.1, on Friday, April 21st, at 10 a.m.

Present.—Drs. J. M. Gibson (Chairman), H. C. Maurice Williams (President), Sir Allen Daley (Chairman of Council), Drs. C. Metcalfe Brown, George Buchan, H. D. Chalke, W. G. Clark, J. Fenton, C. E. Herington, Professor J. Johnston Jervis, Drs. R. H. H. Jolly, Maurice Mitman, A. A. E. Newth, Professor R. H. Parry and Dr. J. A. Stirling. Dr. Anne Mower White attended in the place of Dr. Miriam Florentin who was unable to attend.

45. *Apologies for Absence were Received from* Drs. C. Fraser Brockington, C. K. Cullen, Miriam Florentin, F. Hall and Mr. A. Gordon Taylor.

46. On behalf of the Committee Dr. J. M. Gibson extended a welcome to Dr. H. D. Chalke, who was attending for the first time since his appointment.

47. *Minutes of the Last Meeting held on January 20th* (*Public Health*, pages 137-140, April, 1950) were confirmed and signed by the Chairman.

The Executive Secretary apologised for the lateness in the issue of *Public Health* for April and for the consequent short time which was available for members to read the minutes of the last meeting. The Executive Secretary was instructed to write to the printers calling attention to the lateness of delivery and to ask them to reimburse the Society for the cost of postage involved in sending out circulars to members of the Society giving notice of the ordinary meeting held on the previous evening.

48. *Training of Health Visitors.* (Min. 5.)—The Committee had before them the conclusions and recommendations reached at the meeting of the Liaison Committee on September 29th together with the comments of branches and groups. The comments were fully considered and it was resolved that the recommendations should be amended to read as follows :—

(1) The health visitor of the future should be a fully qualified State registered nurse.

(2) The health visitor and medical social worker of the future should be one, and not two individuals working on parallel and competitive lines.

(3) The fully qualified State registered nurse who decides to take up the full training of a health visitor should, after selection, take her training in a higher educational establishment where training is undertaken for a university degree or diploma in association with practical training in a suitable health department.

(5) Additional special qualifications for medical social workers in rural areas or going to overseas appointments who have additional duties to perform (such as midwifery) would still be necessary.

49. *Whitley Medical Functional Council.* (Min. 6.)—Dr. C. Metcalfe Brown submitted a verbal report on the first meeting of Committee C. The employers side had asked the basis upon which the proposed salary scales had been drawn up and a general discussion followed, after which the meeting was adjourned to enable the employers' side to consider the proposals and to submit counter proposals. The employers' side had undertaken that there should be no undue delay in the consideration of the matter and the Committee was told that the next meeting of Committee C would be held on May 5th.

Medical Officers in the Civil Service. A letter dated was received from the B.M.A. calling attention to the recent decision of the Chancellor of the Exchequer that no increase of salary should be given to medical civil servants. The B.M.A. had decided that in view of this decision it would not accept any further advertisements for appointments for medical civil servants in any of its publications and the Society's support was requested. It was agreed that a similar action be taken by the Editor of *Public Health*.

50. *Dental Whitley Functional Council.*—The Executive Secretary reported that he had learnt that the B.D.A. intended to withdraw from the proposed Dental Whitley Functional Council in view of the Minister's decision further to reduce fees payable to dentists under the National Health Service Act. The public health dental officers would consequently be without an organisation to undertake the salary negotiations on their behalf. It was felt that no consideration should be given to the problem by the Committee until the question had been fully discussed by the Dental Officers' Group.

51. *British Medical Guild.*—It was reported that at the meeting of the B.M.A. Public Health Committee held on March 10th that it had been agreed to set up a Public Health Service Defence Trust and that the subscriptions to the Trust should be collected centrally. It would not now be necessary therefore to ask branches to appoint a member to be individually responsible for the collection of these subscriptions. The Executive Secretary was asked to circulate the necessary information to members.

52. *Transmission of Information from Hospitals to M.O.H.s.*—Following the last meeting of Council a communication was forwarded to the Ministry of Health asking that further consideration should be given to the question of the giving of information to M.O.H.s in connection with the aftercare of V.D. patients. As a consequence of the Society's requests in this matter Circular RHB (50) 22 dated March 7th was issued to Regional Hospital Boards, Hospital Management Committees and Teaching Hospitals in which the following paragraph appeared : "The tracing of V.D. contacts may make it necessary for a clinical M.O. to give information under confidential cover to the county or county borough M.O.H."

53. *The Society and the B.M.A.* (Min. 19.)—The Executive Secretary reported that following the last meeting of Council a letter had been sent to the B.M.A. regarding the recommendation made at the conference between representatives of the Society and the Association on January 20th. As a result it had been agreed to amend the recommendation in paragraph 1 by the insertion of the words "(other than ophthalmic)" after the word "investigation" in the original recommendation. The Council of the B.M.A. had decided at its meeting on April 5th to approve the recommendation and the principles now approved would go forward to the annual representatives meeting as part of the B.M.A. Council report.

54. *Smallpox Consultants.*—The resolution of the County District Group in the following terms had been referred to the Council for consideration by the Committee :—

"The County District Group express the opinion that the medical officer of health of county districts is the right and proper person to call in smallpox consultants."

The Committee agreed with the resolution but the matter was not fully discussed as it was understood that it would be one of the items on the agenda at the meeting of the Executive Committees of the County and County District Groups during the Royal Sanitary Institute Conference at Eastbourne. The matter would be considered further at the next meeting of Council to be held in May.

55. *Food and Drugs* (*Horse-flesh*) *Regulations.*—Following the submission of evidence on behalf of the Society by the Standing Sub-committee for Food Matters, the Ministry of Food

had forwarded copies of draft Food and Drugs (Horse-flesh) Regulations with a request of the observations of the Society upon the proposals. The Standing Sub-committee had considered the Draft Regulations and the following letter had been forwarded to the Ministry of Food :—

March 22nd, 1950.

FOOD AND DRUGS (HORSE-FLESH) REGULATIONS

SIR,—I have to refer to your letter of February 20th, 1950, addressed to the Secretary of the Society of Medical Officers of Health, in which the observations of the Society upon the Draft Food and Drugs (Horse-flesh) Regulations are asked for.

The Society welcomes the introduction of legislation to re-enact the provision in Article 5 of the Horse-flesh (Control and Maximum Prices) Order, 1941, now rescinded, which prohibited the sale or preparation for sale of horse-flesh not for human consumption upon premises used for the sale, etc., of horse-flesh for human consumption. We have no observations to submit upon the wording of the proposed Regulations.

The Society note that, in the Minister's view, the power to make Regulations given by the Food and Drugs Act are not sufficient to allow the other provision to Article 5 of the rescinded Order (*i.e.*, the prohibition of the sale, etc., of horse-flesh for human consumption on premises where meat not horse-flesh is sold for human consumption) to be dealt with. We are pleased to learn that this matter will be considered further along with other suggestions sent to the Minister.

The Society is glad to note, also, that the Working Party which is considering the question of manufactured meat products has been asked to consider whether the substance of Article 6 of the rescinded Order should be re-enacted, as we are of the opinion that the powers to deal with this matter conferred by Section 38 of the Food and Drugs Act, 1938, are not adequate for the protection of the public.

The Society welcomes the opportunity afforded of giving its views on this matter, and will be glad to send witnesses to give oral evidence if that is required.

56. *Income Tax Abatement.* (Min. 36.)—The Executive Secretary reported that in accordance with the instructions of the Council he had written to the Secretary of the Royal Society of Medicine to ask if some reduction of subscription could be made in respect of full time members of the Public Health Service who might wish to join the Epidemiological Section of the Society in view of the fact that full time members of the Public Health Service were not allowed income tax abatement on their subscriptions. The Secretary of the Royal Society had replied stating that it was not felt that the reduction suggested could be made. It was resolved to defer consideration pending further investigation.

57. *Child Guidance.* (Council Min. 27.)—It was reported that the Chairman of the B.M.A. Central Ethical Committee had welcomed the suggestion that Dr. A. Morrison should be associated with them in the discussion with the associations of education authorities or with the Ministry of Education on the question of child guidance.

58. *Industrial Health Service.* (Council Min. 28.)—Sir Allen Daley submitted a verbal report of the meeting of the Dale Committee on Wednesday, March 8th, which had been held to enable the Society to submit oral evidence in support of the memorandum perviously submitted. The Society was represented by the President, Dr. H. C. Maurice Williams, Sir Allen Daley, Dr. C. Fraser Brockington, Dr. Stuart Laidlaw, Dr. A. E. Morrison and Dr. J. Greenwood Wilson. A letter dated March 23rd was received from the B.M.A. inviting the Society to send representatives to a meeting to be held on Thursday, May 4th, to discuss this memorandum of evidence. It was agreed that the meeting be attended by the President, Sir Allen Daley, Dr. J. Greenwood Wilson and the Executive Secretary.

59. *Central Council for Health Education* (Council Min. 32.)—The Central Council for Health Education had informed the Society that difficulties had arisen regarding the alterations in the constitution of the Council and the Board of Trade required certain amendments to be made to the revised Articles of Association. It has not been possible therefore to bring the revised constitution into effect on April 1st, the date being postponed until October 1st.

60. *Local Government Manpower Committee.* (Council Min. 33.)—The Committee had before them two paragraphs from the report of the Health Services Panel to the Local Government Manpower Committee which made it clear that the security of tenure of M.O.H.s would not be jeopardised by any recommendation of the Committee.

61. *Formation of a College of Preventive Medicine.* (Council Min. 37.)—The Committee considered a letter from Dr. George Chesney suggesting the formation of a College of Preventive Medicine and correspondence on the same subject in the *Medical Officer* of March 28th and April 8th. Whilst in sympathy with the desire to enhance the status of those specialising in public health, the Committee considered that, in view of (*a*) the cost of the foundation of such a learned body and (*b*) the current uncertainty as to the future prospects of public health, and local government, the time is not ripe for recommending any active steps in this matter.

62. *Amendments to Building Regulations.* (Council Min. 38.)—It was agreed to ask the School Health Service Group for more detailed comments on the health effects of the amendments.

63. *Taking over of School Clinics by Regional Hospital Boards.*—A letter dated February 16th was received from Dr. A. A. E. Newth in which he asks that the Council give consideration to the problem of the taking over of school clinics and appliances by Regional Hospital Boards. Dr. Newth set out in his letter two instances where he had had interviews with the officials of the R.H.B. at which it had been stated that the Board could take over the clinics in question. Dr. Newth had quoted Section 9 (1) of the National Health Service Act and had failed to get a satisfactory answer. Dr. Newth states that since he had written the letter he had heard from the R.H.B. that no interest in the school clinic's property could be transferred to the Board under the Act.

64. *Tuberculosis Service.*—The following letter dated February 17th was received from the Tuberculosis Group of the Society :—

> At its meeting to-day the Tuberculosis Group Committee discussed the way in which the Tuberculosis Service seemed to be developing. From information offered by members it appears that the proper integration of the curative and preventive work which is fundamental to the successful working of the service is threatened by two dangerous tendencies of equal importance. It was stated that there is a move by some local authorities to solve the difficulties inherent in the Ministry of Health dual appointment scheme for chest physicians, by appointing a separate specialist to carry out their duties under the National Health Act. There would seem also to be a tendency for some Regional Hospital Boards to appoint chest consultants to carry out the Board's duties under the Act. This dichotomy cannot but bring about a dual medical responsibility for the care of the tuberculous person and his family, which is undesirable not only from their point of view, but must also be detrimental to the efficiency of both medical officers concerned as they would neither of them have complete handling of what is really one matter.
>
> So to jeopardise the success of the campaign against tuberculosis is the height of national folly, and the Tuberculosis Group Committee urges with all the power at its command that the Council should take action to preserve the unity of the tuberculosis service while there is yet time.

It was reported that an investigation into the administration of tuberculosis services was proceeding under the auspices of the Central Health Services Council and that when the result of this investigation was known it might be desirable for the Society to proffer observations.

65. *National Assistance Act*, 1948.—The following letter dated February 20th had been received from the B.M.A. The letter had been referred to the County Borough and County M.O.H. Groups for consideration :—

February 20th, 1950.

DEAR MR. ELLISTON,—Dr. A. Elliott, County Medical Officer, Kent, has raised the question as to the position of medical officers of health in relation to duties under the National Assistance Act. He inclines to the view that administrative responsibility for services undertaken by local authorities under the National Assistance Act is outside the scope of the medical officer of health's duties.

He expresses the view that some medical officers of health are responsible for all administrative arrangements in connection with the National Assistance Act, in other cases the services are administrated by a chief lay officer, and in other cases medical officers of health have a measure of administrative and advisory responsibilities. I would be most interested to know whether the Society is aware of any particular cases where medical officers of health are in fact required to undertake full administrative responsibility.

Under paragraph 16 of Ministry of Health Circular 70/48, the Ministry envisages a state of affairs where the services

are as far as possible administrated by a lay staff and it is suggested that the local authority should consider the desirability of appointing a senior lay officer to direct the administration of the services subject, in normal circumstances, to the general oversight and responsibility of the medical officer of health.

It was resolved that consideration of the letter should be postponed until a report had been received from the Groups concerned.

66. *International Public Health Association.*—Correspondence between Professor Sand, of Brussels, and the President, Dr. H. C. Maurice Williams, was submitted. It appeared that an Expert Committee called together by W.H.O. had been considering how professional and technical education of medical and auxiliary personnel could be arranged to serve more efficiently the cause of health. They had unanimously expressed the wish that some international organisation be created in the field of public health and allied branches. The Society was asked for an expression of interest in further consideration of the matter. The President had replied that he felt that the Society would give whole-hearted support to the Association if satisfactory financial arrangements could be made. The Committee approved the reply that had been sent by the President but expressed the view that if such an organisation was formed it should be in association with an organisation such as the W.M.A.

67. *Edible Gelatin and Arsenic in Food.*—The Ministry of Food had forwarded to the Society copies of the Food Standards Committee's report recommending standards for edible gelatin and recommending the introduction of statutory limits for arsenic in food. The enquiries had been forwarded to the Standing Subcommittee for food matters for consideration.

68. *Acute Encephalitis (Post Infectious).*—Members of the Committee were reminded that an enquiry had been received from the Ministry of Health for the comments of the Society on the suggestion that it would be useful for the Ministry to collect information about encephalitis (post infectious) notified as a result of the new regulations which came into force on January 1st, and of the use of a pro-forma enclosed with the enquiry proposed to be used for the purpose. The proposals had been circulated to members of the Council and the following comments had been forwarded to the Ministry of Health :—

Sir Allen Daley suggests that it might be preferable to use the phrase "Primary infectious disease associated with encephalitis" on the pro-forma.

Dr. H. L. Barker (M.O.H., Ilkeston).—My only comment is that the enquiry form should give plenty of space under "Infection associated with encephalitis." I have noticed that the cases are often somewhat involved and complications such as blood transfusion or the administration of sera or vaccines have to be mentioned.

Dr. M. Mitman (River Hospital).—The difficulty I foresee about the notification of post infectious encephalitis is that it introduces a new practice, *viz.*, the notification of a complication of an infectious disease. It is true that influenzal pneumonia is notifiable, but the principal disease, influenza, is not. In the case of encephalitis associated with notifiable diseases such as measles, smallpox, etc., the principal disease will have been notified already. As the encephalitis most commonly occurs in the course of illness, its notification is likely to be overlooked if the principal disease has been notified. If not overlooked it will mean that the same patient will be notified twice, one for the principal disease and the second time for the complication.

Dr. F. R. O'Shiel (M.O.H., Stepney).—I am in agreement with the draft letter, but would suggest that the last column, "Infections associated with encephalitis," should have a little explanatory note added.

69. *Midwives and Ambulance Duties.*—It was reported that a letter dated March 1st had been received from the Royal College of Midwives stating that the College was of opinion that some arrangements should be made to ensure that a midwife was sent with an ambulance when dealing with a maternity case. It was agreed that this letter be placed on the agenda for the next meeting of the Liaison Committee.

70. *Tuberculosis Regulations.*—A letter dated March 6th was received from Dr. J. C. Johnston (M.O.H., Docking, Walsingham and Wells) calling attention to the reference in the January issue of *Public Health* (page 69) to the statement that the Tuberculosis Regulations had lapsed. It was reported that further enquiry had revealed the fact that the regulations were still in force although some revision was necessary.

71. *Subscriptions to the B.M.A.*—Dr. R. H. G. H. Denham, Secretary of the West of England Branch, had forwarded a copy of a letter received from Dr. M. A. Charret (Weston-super-Mare) with regard to subscriptions to the B.M.A. It was stated that the B.M.A. was giving consideration to this question.

72. *Epidemiological Investigation.*—It was reported that the County M.O.H. Group had recently discussed the question of county M.O.H.s and district M.O.H.s in relation to the epidemiological investigation of infectious diseases. The attention of the Committee was drawn to the passage on page 213-214 of the Chief Medical Officer's report for 1948 which makes it clear that the primary responsibility for epidemiological investigation is attached to the district M.O.H.

73. *Iodized Salt.*—A letter dated March 22nd was received from the Ministry of Food enclosing a copy of the Food Standards Sub-committee's report on iodized salt. The report outlines the measures necessary to implement the recommendations of the Medical Research Council endorsed by the Ministry of Health Standing Committee on Medical and Nutritional Problems, that prophylaxis against thyroid enlargement and goitre by the general use of iodized salt is desirable in Great Britain. The Committee had no observations on the Committee's recommendations.

74. *Meat Inspection.*—It was reported that Drs. W. R. Martine, Charles White and the Executive Secretary had attended the meeting on March 25th of the Inter-departmental Committee on Meat Inspection to give oral evidence in support of the memorandum forwarded on behalf of the Society. The Committee had been particularly concerned with the question as to whether the guidance previously given in Memorandum 62/Foods should be re-issued by regulation thus giving it statutory force. The Society's representatives had advised that this should remain a memorandum of guidance only.

75. *Regional Hospital Boards.*—It was reported that new appointments to fill vacancies caused by the retirement in rotation of one-third of the members of the R.H.B.s of England and Wales included that of Professor Leslie Banks, of the East Anglian Board. Professor J. M. Mackintosh had been reappointed to the North-West Metropolitan Board. These were the only Public Health Service members to be appointed. The Executive Secretary was instructed to write to the C.M.O., Ministry of Health, calling attention to his previous letter in which it was stated that when opportunity arose Public Health Service representatives would be appointed to the Hospital Boards.

76. *Supply of Glasses for School Children.*—The following resolution, passed by the Council of the National Association of Head Teachers, had been forwarded to the Ministry of Education and the Ministry of Health and had been forwarded to the Society for information.

> "The Council of this Association deplores the delays in the supply of glasses for school children. It points out that for children to be handicapped by the lack of glasses, or glasses not suited to pupils' requirements, means a serious handicap in their educational training and development. For a pupil to be without glasses for as much as six months, may mean the imposition of a handicap which will go through the whole of the school life of the child. We therefore urge the Ministry of Health to take steps to grant priority for the supply of glasses to children who need them."

It was resolved to receive this resolution.

77. *Foot Health Educational Bureau.*—A letter dated March 29th was received from the Foot Health Educational Bureau inviting the Society to arrange for a discussion of foot health during the National Foot Health Week. If the Society were interested facilities would be given for a meeting to be held in the Central Hall Exhibition from 3.45 p.m. to 5 p.m. on June 14th. It was stated that the M. & C.W. Group were interested in this suggestion.

78. *Purchase Tax on Gas Water Heaters.*—A letter dated March 31st was received from Dr. J. L. Burn, Salford. The letter called attention to large numbers of sub-standard houses in the country which but for the war would have been demolished but which would have to remain occupied for many years to come. Many of these premises could be substantially improved if an ample supply of hot water was available for domestic and personal cleanliness. The purchase tax on gas water heaters was 66⅔% and Dr. Burn asks the Society to give consideration to making a recommendation to the Chancellor of the Exchequer to see if he would remove or reduce the purchase tax on such heaters. The Committee was sympathetic to the suggestion but it was not felt that it could take any action in the matter.

79. *Domiciliary Patients Suffering from Cancer.*—A letter dated April 23rd from the Marie Curie Memorial stated that it was proposed to have a national survey in conjunction with the Queen's Institute of District Nursing into the needs of patients suffering from cancer and who were being nursed in their

own homes. It was hoped to obtain the co-operation of M.O.H.s and it was proposed to send to them a letter and questionnaire (copies of which were before the meeting). Dame Louise McIlroy, Professor Russ, Dr. Greenwood Wilson and the Secretary of the Marie Curie Memorial attended the meeting and outlined their plans. It was pointed out to the representatives that each local authority would decide on the measure of support that could be given to the survey but that the Society would inform its members that they were in sympathy with the purpose of the survey and that if they had any suggestions to make for amendments to the letter or questionnaire these should be forwarded to Dr. J. Greenwood Wilson, who was a member of the Society and of the Marie Curie Memorial.

80. *Puerperal Pyrexia Regulations,* 1939.—The following letter dated April 3rd was received from the Ministry of Health :—

April 3rd, 1950.

PUERPERAL PYREXIA REGULATIONS, 1939

DEAR MR. ELLISTON,—We are now considering referring to the Standing Advisory Committee on Maternity and Midwifery the question of the continuance of notification of puerperal pyrexia. Before this is done we thought that the Society might wish to express its views.

The definition of puerperal pyrexia in the regulations is hardly satisfactory and if notification continues it would need to be modified. There is, however, increasing doubt as to the value of notification. Notification has always been incomplete and is probably now becoming progressively less complete. The statistics obtained therefore are of little value centrally, and it seems that the only justification for continuance would be the value of the procedure locally in obtaining treatment or in prevention of spread. The domiciliary consultative service is now a matter for Regional Hospital Boards and not for local authorities to which notifications are addressed. Control of infection in hospital wards is primarily the responsibility of hospital staffs, and even in the smaller units it is expected that one member of the medical staff would have general oversight for this purpose. Private nursing homes raise a difficulty, though here the rules of the Central Midwives' Board may ensure that the local supervising authority has sufficient information.

I should be grateful if you would let me have any views the Society may wish to express. If you would like someone to come along and discuss this, I should be glad to arrange it.

Dr. Godber, of the Ministry of Health, attended the meeting and expressed the Ministry's point of view on this suggestion. The matter was carefully considered but it was felt that the regulations with regard to notification are helpful and should remain. Dr. Godber stated that if it was decided to redraft the regulations the Society would be consulted.

81. *Royal Sanitary Institute and Sanitary Inspectors Examination Joint Board.*—The question of the Society's representation on the Royal Sanitary Institute and Sanitary Inspectors Examination Joint Board was considered and it was resolved that the Society should be represented by Drs. J. M. Gibson, C. Herington and Hamilton Hogben.

82. *London Conference on Diseases of the Chest.*—The President submitted a report of a meeting called by the British Tuberculosis Association to consider the arrangements to be made for the London Conference on Diseases of the Chest to be held during the Festival of Britain. After hearing the report the Committee resolved that the matter be left in the hands of the President.

83. *Representation of the Society.*

(*a*) *British Council for Rehabilitation*—Dr. Struthers. It was resolved that the Society was not able to pay any subscription to this Council.

(*b*) *British Standards Institution Committee for Upholstery and Bed-Fillings*—Dr. J. J. Buchan.

84. *Election of Public Health Service Representatives, B.M.A.* —Two Public Health Service members of Council : Drs. C. Metcalfe Brown and J. M. Gibson. Four P.H.S. representatives on the Representative Body : Drs. G. F. Buchan, James Fenton, R. H. H. Jolly and J. A. Stirling. Two Deputy Representatives : Professor W. M. Frazer and Dr. F. Hall.

The A.R.M. will be held at Southport from Thursday, July 13th, to Monday, July 17th.

85. *Legal Standards of Disinfectants.*—A letter dated April 17th was received from Dr. J. L. Burn asking for legal standards for disinfectants. It was resolved that the question be referred to the Medical Research Council.

86. *General Nursing Council.*—The attention of the Committee was drawn to the recent decision of the returning officer in the election for the General Nursing Council for England and Wales. It was felt that the decision was very unfortunate but that the Society could not take any action in the matter.

87. *New Offices of the Society.*—After hearing the report of the Hon. Treasurer it was resolved that the furniture and equipment for the new offices and committee room of the Society be purchased at a total cost of approximately £360.

88. *Banking Account.*—It was resolved that arrangements be made to transfer the Society's banking account to the Westminster Bank, Ltd., Tavistock House Branch.

There being no other business the meeting was declared closed at 12.50 p.m.

MIDLAND BRANCH

President: Dr. W. R. Martine (Sen. Asst. M.O.H., Birmingham C.B.).

Hon. Secretary: Dr. W. Alcock (M.O.H., Burton-upon-Trent C.B.).

The first meeting of the Session was held at Lancaster Street Welfare Centre, Birmingham, on Thursday, October 13th, 1949, at 3.15 p.m., there being 21 members present.

It was noted, with regret, that Dr. Anderson was prevented from attending by illness, and the Secretary was instructed to send him a letter of sympathy and the best wishes of the Branch for a speedy recovery.

Dr. W. Alcock, the retiring President, in welcoming the incoming President, Dr. W. R. Martine, referred in appreciative terms to the latter's past services and wished him a happy and successful year of office.

Dr. Martine, in taking the chair, thanked the Branch for the honour they had conferred upon him.

The President then referred to the retirement of Dr. Paul as Branch Secretary, Dr. Gibbons Ward as Honorary Treasurer, Dr. Wyndham Parker as Honorary Auditor, and Dr. Jolly as a Branch representative on the Council of the Society. These Officers had guided the Branch through difficult years, and their unfailing help, both to the Branch and individual members, was much appreciated.

It was also agreed that the congratulations of the Branch should be extended to Dr. Jolly upon his election to the Council of the Society under Article 19(d) of the Association.

The President then delivered his address: "The work of the Services Hygiene Officer in relation to Civil Public Health." (This was published in the February issue of *Public Health*).

At the close of the address, Dr. Griffin proposed a vote of thanks, which was seconded by Dr. Clayton.

Annual Dinner.—As one of the members present had strong opinions as to the desirability or otherwise of holding an annual dinner, the Secretary was instructed to circularise all members and to obtain their views.

The second meeting of the Session was held at Lancaster Street Welfare Centre, Birmingham, on Thursday, November 3rd, 1949, at 3 p.m. Twenty-six members were present, and a visitor, Professor Florelo, of Colorado.

As, in response to a circular letter, a majority of members stated they were not in favour of holding an annual dinner, it was decided not to hold one during the present session.

The Hon. Treasurer (Dr. Gibbons Ward) presented his annual report and balance sheet for the Session 1948-49, which were approved.

Public Health Since 1918

Dr. Jolly then gave an address with the above title. He described it as some random reflections and recollections.

The speaker described his early training in the hard school of experience. It was interesting to learn that salary scales for Public Health Medical Officers were a dominant theme when Dr. Jolly first became Secretary of the Branch and a member of Council in 1922. He felt we were on much stronger ground in our present struggle than we were then, in view of the Spens Committee's reports on the remuneration of general practitioners and specialists, the recommendations in which the Minister of Health has agreed to implement.

Dr. Jolly offered some very interesting advice to aspirants to a chief's post, and gave instances of the difficulties of persuading committees and staff to adopt new ideas. He had always been a firm believer in propaganda, but in his opinion it had to be steady and continuous and flung at people where they could not easily avoid it. Exhibitions, Press articles, and talks to local organisations, were all good, but public meetings rarely attracted any but the converted, and posters were apt to be overshadowed by the advertisements of big commercial firms. If posters were to be successful, they should be issued nationally, *e.g.*, those of the Ministry of Health on Diphtheria Immunisation. He considered that the cinema and broadcasting were the two most effective media.

Dr. Jolly had always found it a most interesting experience to meet and discuss with other public health medical officers their

troubles and difficulties, and found his work on the Council of the Society most valuable in this respect.

He referred to the many distinguished men and women who had striven to improve the status of the Public Health Service, and noted with satisfaction that we stood in better favour now with our general practitioner colleagues than ever before.

Dr. Jolly concluded his address, which included several amusing anecdotes, with an appeal on behalf of the work of the medical charities, notably Epsom College and the Royal Medical Benevolent Fund. The Medical Officer of Health has all the machinery at his disposal for helping these bodies, and he appealed to more members to volunteer to act as Local Secretaries.

The President congratulated the speaker upon his paper, but observed that he had omitted to mention the valuable service which, as Vice-President, he had rendered to the National Smoke Abatement Society.

The President then welcomed Professor Florcio, who thanked the Branch for their invitation. The address might well have been given in the U.S.A., which had gone through all the same phases, and our National Health Service was at present being keenly studied over there.

Drs. Clayton, Starkie, and Tudor Lewis also took part in the discussion.

Dr. Jolly, in reply, said he was very gratified at the reception his remarks had received.

A vote of thanks was proposed by Dr. Clark, seconded by Dr. Gibbons Ward, and carried with acclamation.

The third meeting of the Session was held at Lancaster Street Welfare Centre, Birmingham, on Thursday, December 1st, 1949, at 3 p.m., there being 27 members present.

B.C.G. Vaccination

Dr. J. E. Geddes, Chief Clinical Tuberculosis Officer, Birmingham, gave an address on this subject. He referred, in considerable detail, to the early work of Koch, Trudeau, and Nocard, to produce an effective immunising agent against tuberculous infection—work which culminated in the isolation by Calmette and Guerim of a strain of bovine tubercle bacilli, which, after 15 passages on a glycerine-bile-potato medium, was claimed by them to have become so attenuated in virulence, as to be no longer lethal to a guinea-pig. By 1920, Calmette claimed that this attenuated property of the organism had become fixed, and although this claim has been challenged, there appears to be no authentic record of a re-establishment of virulence, where the strict conditions for growth, as laid down by Calmette, have been followed.

Dr. Geddes, who has recently visited Denmark, in order to obtain first hand information on the use of B.C.G., then described the method of preparation of the vaccine in the State Serum Institute in Copenhagen, the strict precautions taken against accidents, and the tests for sterility, virulence, and potency. He then gave brief details of the technique of vaccination.

Dr. Geddes, as a result of his enquiries, came to the conclusion that local reactions to the vaccine had, in Denmark, given no cause for concern, and the incidence of complications, *e.g.*, abscess formation, were low.

Dr. Geddes, in a critical survey, then referred to the evidence for the efficacy of B.C.G. There appears to be ample evidence to show that in *selected groups* exposed to *heavy contact risks*, B.C.G. affords protection against the type of disease which may follow natural primary infection. But the results are difficult to assess, and incontrovertible proof of the efficacy of B.C.G. is lacking.

Finally, Dr. Geddes pleaded for a controlled trial of B.C.G. Vaccine, in order that its value might be finally assessed.

An interesting discussion followed, in which Drs. Clayton, Ramage, Preston, Lowe, Newsholme, and Lawson, took part.

A hearty vote of thanks was accorded to the lecturer by Dr. Jolly, which was seconded by Dr. Pickup, and carried unanimously.

Other Business.—The Secretary reported that he had received a letter from Dr. Ramage regarding the recent Milk Regulations, pointing out the desirability of ensuring some standard of uniformity, in the granting of licences, and the supervision of pasteurising plants. Dr. Ramage suggested a meeting of M.O.H.s and Sanitary Inspectors, to discuss the matter.

On a proposition of Dr. Wyndham Parker, seconded by Dr. Savage, it was agreed that a special meeting of the Branch should be held to discuss this matter, and that M.O.H.s of Food and Drugs Authorities should invite their Milk and Dairies Inspectors to attend.

It was also resolved to invite Dr. Lethem, Chief Medical Officer. Ministry of Food, or his nominee, to attend the meeting and lead the discussion.

The Secretary also reported that he had received a communication from Dr. Gibson, Honorary Secretary of the Yorkshire Branch, asking for information on the medical grading of M.O.H.s who are Medical Superintendents of Fever Hospitals. The necessary information was being obtained from the Senior Administrative Medical Officer of the Birmingham Regional Hospital Board, and the Secretary's action in this matter was endorsed.

WEST OF ENGLAND BRANCH

President:

Hon. Secretary: Dr. R. H. G. H. Denham (M.O.H., Bathavon and Frome; A.C.M.O., Somerset).

A meeting of the West of England Branch of the Society was held at the Central Health Clinic, Tower Hill, Bristol, on Saturday, April 1st, 1950. The President and 13 members were present.

The Hon. Secretary reported that support for the resolution submitted to the Council of the Society regarding salaries and conditions of service had been received from the Metropolitan, Welsh, Yorkshire and Northern Branches and from the Maternity and Child Welfare, School and Tuberculosis Groups of the Society.

A letter had also been received from the Executive Secretary in which he stated that the Council had resolved to support the resolution and that it had been forwarded to the B.M.A.

It was proposed and seconded and carried unanimously that Dr. Peters, formerly medical superintendent of the City Fever Hospital, Bristol, be recommended for life membership of the Society.

The Hon. Secretary reported the receipt of some correspondence received from Dr. Charrett regarding the reduced rate of annual subscriptions conceded to whole-time university teachers and scientific research workers by the B.M.A. He produced evidence to show that the position of the assistant M.O.H. was infinitely worse than that of the whole-time university teacher and suggested that a resolution might be sent from the Branch asking for a reduction in our rates of annual subscription to the B.M.A. Dr. Charrett's correspondence had been submitted to the Executive Secretary and a reply had been received to the effect that the matter would be considered by the General Purposes Committee at their next meeting.

Problem Families in Bristol

Dr. Wofinden addressed the meeting on a subject which has claimed a great deal of his time and interest, that of problem families in Bristol. He began by explaining that in 1947 the Eugenics Society set up a Problem Families Committee with a view to conducting six pilot enquiries in different parts of the country into problem families. He outlined the method that had been used, which, if successful, might lend itself for use in a national enquiry provided an interdepartmental committee could be formed for this purpose.

He explained that there was a great need to assess how many problem families there were in this country and to study their main characteristics with a view to trying to ascertain aetiological factors and institute preventive measures. He then went on to describe the results of his experience in the Bristol pilot enquiry.

In general he had found that the method used was rather cumbersome and he made suggestions as to how it could be simplified. Notwithstanding the Bristol experience he still found it impossible to devise a more precise definition of a problem family than any which had already been given, but he pointed out that this might be possible after studying the accumulated data from the six enquiries. The main findings in Bristol were as follows:—

(1) That there is a hard core of problem families (not a great number) within the city.

(2) Nearly 60% of these families are at present living on relatively new housing estates.

(3) They are large families with a high average number of children (5·8) and 11·4% of these children are subsequently removed from the parents and become a direct charge on the State.

(4) Child neglect in the sense of persistent uncleanliness, repeatedly suffering from scabies, impetigo and verminous infestations, frequent lameness or absence from school, etc., was present in 90% of the cases.

(5) There appears to be a high rate of illegitimacy in these families and juvenile delinquency seems to be a natural and subsequent corollary.

(6) The intelligence of a high proportion of both mothers and fathers was a good deal below normal.

(7) A high proportion of the children were educationally retarded.

(8) There was physical ill-health in over 50% of the mothers and, if mental health was taken into account, in a far greater proportion of mothers and also in many of the fathers.

(9) Over half the families in Bristol seem to have insufficient money for their basic needs. This was not a surprising finding in view of the fact that over half the fathers enjoy but a precarious form of livelihood, being either unemployed or only casually employed.

(*Continued on page 206*)

(10) The findings of the Herefordshire enquiry that the infant mortality rate was twice as high in problem families as for the rest of the population was not borne out in the Bristol enquiry.

Dr. Wofinden then went on to outline the recommendations that he had made to the City Council for dealing with these problem families. He pointed out that the first necessity was to place the responsibility for their welfare on one department and one officer of the municipality. He thought a good deal might be accomplished by this officer calling periodic case conferences to discuss each case not only with all the other officers who might be concerned with problem families,, *e.g.*, education, welfare, housing, children's officer, etc., but also with representatives from voluntary organisations. In view of the large number of mothers who were suffering from ill-health, better provision should be made for their convalescence.

Bristol Corporation were trying to promote a Private Bill in Parliament at the present time and powers were being sought in this Bill for the provision of social rehabilitation centres for mothers and families, for the employment of home advisers, and for the provision of furniture and/or furnishings free of charge or on loan to such cases. Dr. Wofinden had been of the opinion that these powers might have been sought under Section 28 of the National Health Service Act but had been advised by his legal department that such powers were not likely to be granted under this Section.

In dealing with housing policy he suggested that problem families should not be re-housed directly on to new Corporation estates when they had been past occupiers of slum areas, but should be made to graduate by occupying a "half-way house." If and when they proved that they could live a decent hygienic way of life then they might be moved into a new house.

With regard to birth control, in his experience very few such families were either willing or capable of putting the advice into practice. There seemed to be a number of families where sterilisation after the birth of the first or second child could probably prevent them from becoming problem families, for there is no doubt that many of these families have a low threshold to stress, this threshold being exceeded very easily with increasing family size.

A lively and interesting discussion followed and a vote of thanks to Dr. Wofinden for his able address was proposed by Dr. McGowan and seconded by Dr. Bramley.

COUNTY DISTRICT MEDICAL OFFICERS OF HEALTH GROUP

President: Sir Allen Daley (M.O.H., London).
Hon. Secretary: Dr. T. Ruddock West (C.M.O.H., Norfolk).

At the monthly meeting on April 14th, 1950, the President was in the chair and 23 members were present. Considerable discussion took place concerning a possible revision of the existing immunisation and vaccination record cards. Mr. J. R. Simpson, Director of the Organisation and Methods Division of H.M .Treasury, gave a most interesting talk on the work of his Division in Government departments which was greatly appreciated. Discussion ensued, members putting forward their views on organisation and methods in relation to the varying types of local authorities. (It is hoped to publish Mr. Simpson's paper in a forthcoming issue of *Public Health*.)

SCHOOL HEALTH SERVICE GROUP

President: Dr. A. A. E. Newth (Sen. S.M.O., Nottingham C.B.).
Hon. Secretary: Dr. A. Morrison (Sen. S.M.O., Derby C.B.).
Assistant Hon. Secretary: Dr. J. B. S. Morgan (S.M.O., Derbyshire).

An ordinary meeting of the Group was held at London on Friday, January 27th, 1950.

Dr. J. E. Cheesman was in the chair, and 25 members and guests were present.

The weather was very inclement and there were 20 apologies for absences received.

Twenty new members were elected to the Group.

The Hon. Secretary reported briefly on Group affairs.

A meeting of the Council had been held on January 27th, at which the following subjects were considered: Preventive and corrective physical training in school children; modification of Form 4.H.P.; a proposed new form for the deaf and partially deaf, and the report of a Joint Committee on the specifications of a standard weighing machine. Subjects for further consideration were the choice of employment and supervision of handicapped pupils and conditions regarding young people entering industry. The question of refresher courses was also discussed. The Society had asked the Group for its observations on rubella in pregnancy, and the training of health visitors, and these had been submitted.

The President, Dr. A. A. E. Newth, then gave his presidential address on "What is Child Guidance?" This is published separately on page — . The address evoked keen discussion and many questions, and these indicated the high degree of interest which had been created by the address.

A cordial vote of thanks to Dr. Newth was proposed by Dr. H. M. Cohen.

TUBERCULOSIS GROUP

President: Dr. T. W. Davies (Chest Physician, Swansea).
Hon. Secretary: Dr. R. L. Midgley (M.S., Hawkmoor Sanatorium, Devon).

Group Committee Meeting

A meeting of the Tuberculosis Group Committee was held at the rooms of the Society at 10.30 a.m. on Friday, May 19th, 1950.

The Vice-President, Dr. R. M. Orpwood, occupied the chair, and there were present Drs. G. B. Charnock, J. G. S. McQueen, J. S. Harper, H. Ramsay, H. Vallow, G. Lissant Cox, C. K. Cullen, G. M. Townsend, S. H. Graham, B. R. Clarke, R. L. Midgeley.

Apologies for absence were received from Drs. N. Tattersall, G. M. Barker, J. W. Wilson, T. W. Davies, P. W. Edwards and J. E. Geddes.

The Chairman told the meeting of the sudden death on May 7th of Dr. T. R. Elliott, a valued member of the Committee. The meeting stood in memory of Dr. Elliott. The Hon. Secretary said he had written on behalf of the Committee to Mrs. Ring, sister of Dr. Elliott.

There were no special matters arising from the minutes, which were read and signed as a correct record.

The Council representative presented his report and commented upon items in the published reports of the Council and General Purposes Committee meetings. There was nothing of a controversial nature.

The Joint Tuberculosis Council representative presented his report. It was noted with satisfaction that three members of the Committee, namely, Drs. P. W. Edwards, N. Tattersall and R. L. Midgley, were now Chairman, Vice-Chairman and Hon. Secretary respectively. It was reported that a new series of specimen record forms would shortly be available for use in chest clinics.

The memorandum of recommendations for the training of health visitors was discussed, and the following resolution was passed by 11 votes to 1: "This Committee agrees that the health visitor must be a qualified nurse, but believes that because modern social conditions have become so complicated this work cannot properly be combined with the nursing duties of a health visitor. The medical social worker should work with the health visitor on parallel and complementary rather than competitive lines."

Ministry of Health Form T.145 was considered and thought to meet the purpose for which it was designed. The only section over which there was discussion was D. (2). It was felt that this was a rough and ready way of finding the amount of gross infection in a clinic area, and its inclusion might stimulate more sputum testing where this was needed. It was noted with satisfaction that the issuing of R.H.B. (50) 22 makes clear the duties of hospitals in regard to the transmission of information to medical officers of health concerning the infectious diseases including tuberculosis.

Officers and Representatives for Session 1950-51.—The following officers, representatives and co-opted members were nominated for 1950-51 and elected by the ensuing annual meeting:—

President: Dr. R. L. Midgley.
Vice-Presidents: Dr. T. W. Davies, Dr. G. M. Townsend.
Hon. Secretary: Dr. J. G. S. McQueen.
Council Representative: Dr. C. K. Cullen.
Joint Tuberculosis Council Representatives: Dr. C. K. Cullen, Dr. J. G. S. McQueen, Dr. R. L. Midgley.
Inter-Group Committee Representatives: Dr. T. W. Davies, Dr. R. L. Midgley, Dr. J. G. S. McQueen.
Co-opted Members: Dr. P. W. Edwards, Dr. N. Tattersall, Dr. G. Lissant Cox.

The next meeting of the Committee will be held at 10.30 a.m. on Friday, September 15th, 1950, at the rooms of the Society.

Printed by H. R. Grubb, Ltd., Croydon, and Published by The Society of Medical Officers of Health, Tavistock House South, Tavistock Square, W.C.1.